AN ABSTRACT OF THE THESIS OF

Kristin Naserian Hedges for the degree of Master of Arts in Applied Anthropology presented on April 29, 2005.

Title:  *Ukimwi ni Homa (AIDS is a cold): HIV Vulnerability of Maasai Women*

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This thesis takes an in-depth look at specific behaviors that are putting Maasai women at risk for HIV/AIDS in Kenya. Methods used include in-depth interviews, focus group discussion, demographic data collection, and nutritional anthropometric measurements. The research took place June – September 2004. Analysis reveals a strong connection between poverty and risk for HIV/AIDS in the Maasai community. There is also the potential for “learned helplessness” that some young women are displaying due to the current HIV/AIDS intervention and awareness programs. The thesis considers how culturally appropriate interventions may be more effective than current education programs at lowering the rate of HIV/AIDS in the Maasai community.
Ukimwi ni Homa (AIDS is a cold):
HIV Vulnerability of Maasai Women

by
Kristin Naserian Hedges

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Kristin Naserian Hedges, Author
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Ukimwi ni Homa (AIDS is a cold): HIV Vulnerability of Maasai Women

Introduction

This research project evolved from my years in Kenya. I lived in a small town, Narok, Kenya from 2000 to 2003 as a Peace Corps Volunteer, specifically as a public health worker. The Narok Town Council had requested the Peace Corps assistance to work on HIV/AIDS issues. So, after two and half months of training in Kenya by Peace Corps I was sent to Narok. Throughout my time there I endured many personal and emotional reactions to my role as an HIV/AIDS volunteer. Looking back it was similar to Hofstedt's reference (1991) to "culture as an onion". I arrived in Narok a young, eager, idealistic volunteer, anxious to start working and teaching about HIV/AIDS. Then I discovered deeper levels of cultural awareness, and each time I felt overwhelmed and worried that I was in over my head. The struggle was that these onion layers were not only those of this new culture I was living in but also those of a terminal disease.

My first onion peeling moment came when a women who was HIV positive wanted advice and help. I remember being completely overwhelmed, thinking I had no idea what to say. After a while I got use to this layer and learned what advise might actually be helpful for those living with AIDS. The second moment occurred after testing one of my first positive clients. She was a young mother, about 19, and had her nine-month-old baby with her. After hearing the results she simply lost it, bawling hysterically as I sat staring at her baby. I thought, What am I doing? I can't do this! The third experience happened as a close friend of mine was dying of AIDS. The doctor never told her the diagnosis, but felt at ease telling me. I will never forget her thin face as she looked at me and asked, "Naserian, hiyo mjonjwa ni nini?" Naserian, what is this disease? And what did I do? I gave her the culturally appropriate and expected answer even though I knew it was a lie. "Utapona." You will heal. With each discovered layer of the culture I was living with and of their struggle

1 Naserian is my Maasai name
2 All quotes throughout this thesis have been translated by myself from Ki-swahili to English
with this disease, I felt out of my element and overwhelmed. But I learned how to manage and tried to help.

One of my main roles, especially during the first year and a half in Narok, was to conduct HIV/AIDS awareness presentations. Peace Corps had taught us the basics of transmission, prevention, and development along with recommended methods for teaching this information to a variety of audiences. Out I went to bus stands, markets, local schools, and community groups to educate others about HIV/AIDS. One presentation stands out in my mind. I was talking to a small women’s group that ran one of the local corn mills. There were about 20 to 25 Maasai women sitting in this small alley next to the mill as I tried my best to teach them about transmission and, more importantly, prevention. I explained the options for prevention. When I got to condoms a few women said this was impossible. If they asked their husband to use a condom, they explained, their husband would beat them. At first I was shocked. Then I asked if they could use condoms with their boyfriends. That was possible, they said, and we agreed this protection was better than nothing.

I left feeling so proud of myself. I had lived with this community long enough to know some of their cultural norms, such as open sexual relations. My knowledge of community behavior helped me recommend a modified strategy for condom use. It wasn’t until some time later that I realized how wrong this was. Why should communities have to modify an intervention to fit their culture? Interventions should be designed within and as part of their culture.

After I finished my service with the Peace Corps, I still wanted to continue working with cultural groups, assisting them in their struggle with disease. Even more, however, I wanted to help design specific interventions for specific cultures. This is how I ended up at OSU, getting my Master’s in Applied Anthropology with an emphasis on Health and Culture. With this experience and education, I returned to Narok, Kenya.
Chapter 1

BACKGROUND

1.1 AIDS in Kenya

HIV/AIDS is the largest killer of any single infectious agent and has claimed more than 30 million lives worldwide. Nearly 5 million people are newly infected with HIV each year, and more than 95% of them are in developing countries (www.who.org). The highest rates of infection are in Sub-Saharan Africa. It is estimated that AIDS began spreading in Kenya during the 1980's, however the Kenyan government refused to officially recognize AIDS as a problem until 1999. After 5 years of intensive and widespread interventions, the results from the 2003 Kenya Demographic Health Survey (KDHS) indicated a 7% HIV positive rate for Kenyan adults (Central Bureau of Statistics [CBS] Kenya: 221). While these latest results are encouraging, the epidemic is still present in Kenya and new interventions are needed. Surveys show that 98.5% of Kenyans have heard of HIV/AIDS, are aware of the ways the virus is transmitted, and are aware of options for prevention (185). With 98.5% awareness and 7% prevalence, it is obvious that risky behaviors are still being used. Awareness is apparently not enough to stop its spread.

AIDS is a disease that affects and is affected by multiple aspects of a person's life. From prevention to transmission nearly every sector in a society is influential. For instance, community economics affect a person's prevention strategies. Maybe a young Kenyan mother earns money to feed her children through sexual relationships. Her personal economic situation can affect her HIV prevention strategies. If a woman needs money to feed her children today, she will find a way to do that even if it is risking her health in the future. An HIV-positive person living in a country that does not have health care will be less likely to get treatment for opportunistic infections, and this will in turn affect the transmission rate of the disease. It is essential that research begin to look at the situation holistically. If people are aware of the disease but still unable to change risky behaviors then recommended prevention strategies need to be reevaluated within the local cultural context.
1.2 Present Research

This research was a collaborative effort between the Pillar of Hope (POH) community based organization in Narok, Kenya and myself. I helped establish POH in September 2000 as a local Peace Corps Volunteer with members of the community who came together to support people infected and affected by HIV/AIDS. The organization officially launched its program by opening the first Voluntary Counseling and Testing Center (VCT) for HIV on February 19, 2002 in Narok Town.

Narok Town is about 200km southwest of the Kenyan capital, Nairobi (see Figure 1). The total population of Narok District, as of 2002, is 403,812 (Narok District Development Plan: 8). The district has seven divisions, and Narok Town is located in Central Division (see Figure 2). Central Division has a population of 41,162 as of 1999 (Narok District PRSP 1999: 4). Most of Central Division land varies from semi-arid to forest. On average there are two rainy seasons during the year, but in recent years the rains have been unreliable, affecting the small subsistence farming that is common. Narok Town- where this research took place- is the largest town and the central political headquarters for the entire district.

FIGURE 1: Map of Narok District within Kenya  
FIGURE 2: Map of divisions within Narok District

(©Narok District Development Plan, 2002)
POH is the most active HIV/AIDS group in Narok District. Their VCT center serves on an average of 200-300 clients per month. The center offers ongoing counseling to all clients. They also maintain a demonstration garden to give nutritional advice, especially for HIV positive clients who need to boost their immune system. POH is also very active in HIV/AIDS awareness. Their counselors teach sessions in schools, community groups, the prison system, in addition to locally taught seminars. In the past year POH has become very active in organizing mobile VCT throughout the district. Counselors arrange to take counselors and testing equipment out to another village center in the district and set up a small VCT for one to five days.

In Narok District there are a total of 275 primary schools and 19 secondary schools. Primary schools are often coed, typically day schools, and spread across the district. Primary schools would be the equivalent of U. S. grades 1 through 8. Secondary schools are typically boarding schools, and there are 4 located in Narok Town. School attendance is on the rise for young Maasai women. In fact, 2002 statistics show that 17% of Maasai girls were attending secondary schools, topping 13% of boys (Narok District Development Plan 2002: 10). Many of the participants in my research were attending schools and a few have even reached the secondary school level.

The 2002 year-end statistics for POH show a discrepancy based on gender in HIV positive clients. Between the ages of 20 to 24 years, 17% of female clients are HIV positive while only 1% of male clients have the same status. POH requested research into cultural practices that are contributing to this vulnerability in order to implement culturally appropriate interventions. The POH testing center currently sees about 50% of its clients from Narok Town and 50% from the surrounding villages. All the towns and villages of the district are predominantly occupied by the Maasai tribe.

1.3 Maasai Ethnographies/Research

The Maasai people have captured the attention of travelers, missionaries, and anthropologists throughout history. The first known written description of the Maasai came from a missionary Ludwig Krapf in 1860. "They are dreaded as warriors, laying all waste with fire and sword, so that the weaker tribes do not venture to resist them" (Bentsen 1989: 9). This perception of Maasai fierceness is still prevalent throughout
Kenya and Tanzania. Other tribes are wary of a Maasai warrior, which is why it is commonly accepted that the best watchmen are Maasai. In the West Maasai are a well-known figures published in brochures and coffee-table books. For many Westerners the image of a Maasai is the stereotype they attribute to all African tribes: women adorned with beads, men standing in red sheets on the plains, watching their cattle, one leg propped up.

The Maasai people are currently located in Southern Kenya and Northern Tanzania. It is believed that they migrated from Northern Africa to their present location (cf. Gallaty 1991). Maasai people are defined in many cases by their language, the Maa language. Through the migration south Maasai had a history of adopting and incorporating individual people or entire communities into their social network. It therefore became easiest to define Maasai people through their use of the Maa language. For this reason there are many sub-clans of Maasai today. Each sub-clan speaks slightly different dialect of the Maa language. Participants in my research listed 16 sub-clans in Maasailand. Other texts and historians list more or less. The map below shows the distribution of the sub-clans throughout Kenya and Tanzania. Most of the participants in my research are from the Purko sub-clan, located on the southeastern side of Kenya. There is not enough room in this thesis to give an detailed discussion on the emergence, history, and migration of the Maasai people. For more information please refer to Gallaty (1991), Hodgson (2001), Sutton (1993), and Spear & Waller (1993).

FIGURE 3: Map of Maa Language Groups

(©Deasy Geographics in Sommer & Vossen, 1993)
Generally the Maasai have a reputation in Kenya for maintaining their traditional lifestyle while many other Kenyan tribes are moving toward a more Western lifestyle. The most advertised aspects of this culture are that they are a semi-nomadic, pastoralist, and polygamous community. Semi-nomadic means the population remains in a permanent residence. Herders move livestock to accommodate their food and water needs. Pastoralism refers to livestock production as the primary income source. Maasai pastoralism is well known in Africa for specializing in the breeding of strong and durable cattle. This strong pastoral practice contributes in part to the tribe's expansion and strength in East Africa (cf. Gallaty 1991). While Maasai have survived mostly by pastoralism in the past, today they rely more and more on agriculture. Polygamy, of course, refers to having more than one wife. These are the broad structures that define Maasai culture. Everything in a Maasai's life revolves around marriage and cows.

1.4 Maasai Ethnomedical Beliefs

Maasai cultural lifestyle includes the heavy reliance on local herbal treatments to cure many ailments. Many Maasai feel more comfortable going first to a local medicine women and trying an herbal treatment. If that fails, they may then turn to Western medicine. Herbal uses and cures for disease are taught from an early age. Most adults can tell you a basic treatment for everyday illnesses such as colds, coughs, and fevers. They know which trees and herbs are used and how to prepare the treatment. This summer I fell ill with a severe bronchial cough (most likely from cooking over an open wood fire all summer). The adult members of the boma\(^3\) fixed an herbal drink that cured me in two days time. The drink consisted an herbal bark.

One specific holistic treatment used by the Maasai in East Africa is called the orpul treatment. Young Maasai warriors spend time in a remote site consuming herbs and meat while singing songs and praying. All four aspects must be included for success; herbs, meat, singing, and prayer. The orpul treatment is usually for young warriors to prepare for circumcision or cattle raiding. However, there have also been documented cases of women and elders participating in an orpul due to illnesses (cf.

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\(^3\) *Boma* is the Ki-Swahili word for Homestead
Some of these herbs have been identified as treatments for worms, fever, diarrhea, and malaria (Merker 1910). One health benefit of an *orpul* may be to lower HIV viral load in infected people (cf. Burford 2001: 548).

Other health beliefs and treatment include animal blood and fat. These were explained to me by my participants. Most any illness, ceremony, or experience of reduced strength was treated with animal fat. After every circumcision, for instance, the girl or boy will drink the fat of a goat or sheep. The meat is boiled down until the natural fat is released. In many instances herbs for varying ailments will be added to the liquid fat. The patient will then drink about a half-liter glass, preferably all at one time. The belief is that the fat will help restore strength the body lost during circumcision. The same goes for a woman who has just given birth. The fat will help restore her strength, and the blood the woman is also encouraged to drink will help replace the blood lost during delivery. If a person has been chronically sick or losing weight, family and community members will organize a slaughter to give the person animal fat.

One of the most interesting findings was Maasai perspectives on diarrhea. It is viewed as a very good process in the body, because it purges the body of all the disturbing illness. While this was not new to me, I was more surprised to hear the lengths of which they would go to induce diarrhea. It is well known that drinking animal fat will most likely cause either vomiting or diarrhea. I had assumed this was simply an accepted consequence of the treatment. It was explained to me this summer, however, that inducing diarrhea was the actual goal of drinking fat, because diarrhea would purge all illness out of the body. It is important to have this basic context of Maasai ethnomedical beliefs in order to understand other health perspectives this community.

1.5 Sample Area

The methods chosen for this research are both quantitative and qualitative in order to acquire a holistic understanding of the situation. The most important aspect of this study, however, is that it is from the ground up. The information is therefore relevant and important to their daily lives. This research took place in two small
villages. Both were located in Mfano\(^4\), which is an area just 10 kilometers southeast of Narok town.

I learned of Mfano’s interesting recent history from a key informant. Around 1963 the Kenyan government declared the Mfano area, an estimated 830 acres, to be a group ranch. About 70 different families lived on the ranch in traditional Maasai Manyattas. A manyatta is a cluster of houses connected together, also referred to as a village. In 1999 these families elected a committee to oversee the group ranch. They elected one chairman, one secretary, and one treasurer. This committee decided to split the ranch into individual family allotments. They conducted a census of the residents on the ranch, counting all people over 18 years of age. All males over 18 years of age were then to receive an allotment of 42 acres.

The final allotments did not happen as promised or planned. It seems there was a lot of corruption behind the issuing of plots. Politics and corruption among the three committee members determined a plot’s location and size. Some people received 23 acres while others received more than 50 acres. Those having good relations with the committee received plots close to town, or the road, or a water source. Those not having good relations with the committee received plots in the bush with no convenient resources. After these allotments were made, each man had to pay the committee 5,000 Kenyan shillings—the equivalent of $65 US dollars—to be shown the location of their plot. This amount is extremely high considering the average Kenyan family makes the equivalent of about $1 per day. Residents were told the money was the “survey fee”. Many families struggled and found a way to pay. In return they were shown their plot. They began to build houses and begin farming their land.

As it turned out, the plots were never officially surveyed. Many residents are now being thrown off their plot as official surveyors come to mark legitimate boundaries. Apparently, the committee members simply pocketed the 5,000 Kenyan shillings per family.

\(^4\) A pseudonym has been created for the name of this location.
The ranch allotment and consequent settlement into individual plots has changed residents' lives in every aspect. Time was divided between the era “when we lived in the manyatta” and the era “living in the homesteads”. Since the days of the manyatta, lifestyles have been changing from communal living to a more individualistic system. Families now have their own farms, plots, and houses. They have become more self-reliant. This change in lifestyle has led to numerous changes in custom and tradition. A few examples include the changes in circumcision ceremonies and treatment after pregnancy.

In the manyatta, circumcision required a large celebration with all the children of the same age group being circumcised at once. Circumcision today still involves a large celebration but only with children in the same family being circumcised together. This has led to changes in the age of circumcision. Some are circumcised earlier or later to match that of their siblings. Two sisters around ages 13 and 15 will be circumcised together. Older children wait a bit longer while younger children are circumcised a bit earlier in order to accommodate a family circumcision. In the manyatta, a mother who had just given birth would not be required to work for the first few months. The other women would take over her chores. Today, living on an individual farm, women are required to work immediately after childbirth because there are fewer people present to assist.

Most participants talked about how much better life is now that they have their own plots. One participant explained, “Maasai, ee ee ee⁵, it is hard. These days we have a farm. The old days, we almost died” (Illay). Participants see independent farming and the food supply for their own families as an improvement in the quality of life for their children. They believe this is all possible because they have individual plots.

It is important to have a grasp of this background in order to understand the participants in this study. During my years in Narok I formed close friendships with many women from Mfano. These friendships offered me in-depth awareness of issues Maasai women face day to day, primarily because these women felt comfortable to

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⁵ Ee ee ee, is a phonetic emphasis used in the Maa language usually in response to a difficult situation.
talk freely with me about a wide range of experiences. One of the most important reasons for working in this area was to live with a friend in Mfano. She gave me the unique opportunity for participant observation as a local resident.

The location includes some unique cultural aspects: residents live relatively traditional lifestyles outside of town, but close enough to be influenced by urbanization and Westernization. Most of their lives are in a transition period. In the midst of this transition HIV/AIDS has been spreading rapidly throughout the community. It appears that some of these sociocultural factors contribute to Maasai women's increased risk of contracting HIV in contrast to their male counterparts. Some of these cultural factors have been present from the manyatta days and others have emerged during the farming days. All factors need to be considered in order to understand the prevalence of HIV/AIDS in this Maasai community.

1.6 Trends in AIDS Research

Current trends in the field of HIV/AIDS focus on awareness, testing, and support. Awareness refers to HIV/AIDS education conducted throughout communities, local groups, and schools. Most awareness programs use the A, B, C to teach options for prevention. This stands for "A": Abstain from sex, "B": Be faithful to one sexual partner, and "C": or use a Condom. Testing refers to the many Voluntary Counseling and Testing Centers popping up all over the world for people to learn their HIV status and how to live with the status whether positive or negative. Support refers to the programs that are now being recognized as important to support the millions of people already infected with the disease. Such programs are implemented by UNAIDS, FHI, national AIDS networks, as well as other various private and public, governmental and non-governmental organizations (UNAIDS 2003: 58, FHI 2003). While these programs are extremely important in the fight against AIDS and have been highly successful in some populations, they have also failed in others.

The cause of this failure is rooted in design. Many programs such as awareness, testing, and support have been designed in Western society. Many populations have adopted a more Western lifestyle and relate well to such interventions which are then successful. However, traditional populations have
resisted Western lifestyles and do not relate well to Western based interventions. The interventions only benefit Westernized populations while traditional populations are forced to struggle alone with HIV/AIDS because the interventions have failed them.

Anthropology has a significant role to play in addressing this problem. The solution is interventions that are culturally appropriate. Designing a culturally appropriate intervention is a difficult task. The design must start from the community level, using in-depth qualitative research to understand the risks, challenges, and perceptions of HIV/AIDS from within. This is where anthropologists can use their ethnographic skills: to illuminate those cultural situations that are putting people at risk for contracting the disease, and to help design appropriate grassroots interventions. This disease affects everyone’s lives each day. It is therefore important and essential to understand their lives from personal and cultural perspectives.
Chapter 2

LITERATURE REVIEW

Women’s vulnerability for HIV transmission has been proven in a number of studies across the globe (Bitangaro 2001, Chitamun 2003, Harrison 2001, Weiss 2000). “In South Africa, over one-third of teenage women attending public antenatal clinics are HIV-infected” (Harrison 2001: 69). A similar trend can be seen all over Africa and other developing countries (cf. Weiss 2000: 233). The reasons for this vulnerability vary, but some commonalities exist. I will discuss the suggested risk factors specific to Maasai culture. I will also review studies showing a correlation of these risk factors among other societies.

As mentioned earlier, POH testing shows that among youth ages twenty to twenty-four, women are 17% positive and men are 1% positive. Many African testing sites have shown a disparity between the contraction rates of men and women. HIV transmission is higher among women in Kenya than in other African countries (Central Bureau of Statistics (CBS) [Kenya]: xxiii). This trend, however, is greatly exaggerated in the Narok community. What cultural factors exist in this society that contributes to this strong discrepancy?

Three specific cultural practices may the increased HIV transmission rate among Maasai women: poverty, sexuality, and Westernization through education. Poverty has left young Maasai women searching to earn extra cash through sexual relationships with older men that could expose them to HIV. Sexual identity and experiences that young women learn through social learning since childhood may also be encouraging the spread of the disease. Western influence through education exposes young women to new material goods that the young women have become desperate to acquire and open to sexual liaisons to do so.

2.1 Poverty

Studies suggest a direct correlation between socioeconomic status and HIV transmission. “Vulnerability to HIV and AIDS has increasingly come to be understood as fundamentally linked to questions of social and economic inequality and injustice”
(Parker 2000: 40). This correlation becomes even stronger when focusing specifically on female youth and their relationship with older men.

Traditionally Maasai people redistributed their resources throughout the community with systems such as bride price and livestock exchange. Values and economic systems have been changing dramatically, however, as well as the communal sharing of resources. A new class system based on a Western lifestyle is developing as a result. There are now both rich and destitute (cf. Hodgson 2001: 173).

This change is also affecting the distribution of resources within households (cf. Fried 1960: 288-305). People now want Western clothes, shoes, and education. This was a theme in another study of South African female youths where the desire there was for luxuries they could not afford. One young woman stated clearly, “Some of them come from very poor families and like to have nice clothes” (Harrison 2001: 73). Similarly, this is what Maasai adults and children struggle for. While some resources are still distributed throughout kinship groups, they are no longer equally distributed across the community. These objects are becoming symbols of status (cf. Geertz 1973: 564). These objects are seen as hope for the Maasai children’s profitable future within the stratified Kenyan society. If they can achieve the style and education of a Western society then they may be able to get jobs and find a better way to survive in this changing culture.

Poorer groups are being left behind in this transition, themselves struggling to find a way to possess these new objects. Consequently young Maasai women will go of their own accord or are sent by their parents in search of funds for school clothes, fees, shoes, or household needs such as flour and sugar (cf. Ackerman 2002: 168). Most of these young women will earn what they need by sleeping with older men. This is the notion of “sugar daddies”. It is not considered prostitution. It is simply a relationship of needs. “The ‘transactional nature’ of sexual encounters and relationships in Africa is virtually an article of faith in the social demography and social research on AIDS across the continent” (Setel 1999: 141). The girl assists the older man with his weekly sexual needs, and he assists her with her weekly economic needs. These needs are so strong that they override any personally protective method such as abstinence or condom use. A participant in another study described the
dilemma: “They are not looking for the disease and they are looking for money…. that’s the big problem and in looking for money, they acquire the disease” (Mwale 1992: 38). If she has only one “sugar daddy” she is putting herself at risk for contracting HIV, let alone if she has two or three. The “sugar daddy” will in most cases have at least one wife, if not more, and other girlfriends on the side. The young Maasai woman is then at higher risk for contracting HIV.

This behavior is prevalent in numerous other societies. In South Africa, it was found that “access to money and material goods also played an important role in these young women’s relationships, and in the initiation of sex” (Harrison 2001: 72). A young woman in Haiti, describing the situation of young women and relationships for money, expressed exasperation, “There are too many hungry girls” (Farmer 1996: 20).

One type of intervention that has proven to be effective in informal communities in South Africa is Peer Lead Education. The basic idea is that “prevention programs must include methods for improving their social conditions as well as their sexual risk behavior” (Lutchmia 2003: 502). This is an educational training program for local women. The women were trained as local peer educators on sanitary health conditions and HIV prevention.

2.2 Sexuality

“Sexuality is about much more than what takes place on an interpersonal level between sexual partners; it is embedded in a whole array of contextual forces that are antecedent to any particular encounter” (Setel 1999: 16). We must first understand the type of relationships that young women are in and the forces around these relationships—“to understand culturally-influenced ideal-type identities and the sexual risks that concur with them” (Herdt 1997: 16)—and then we will be able to understand the risks that are encouraging the spread of HIV.

“Sexuality cannot be abstracted from its surrounding social layers” (Ross & Rapp 1997: 155). Socialization teaches us our sexual identity within a culture. In this process we learn who we are expected to be as well as what gender roles and responsibilities we are expected to assume. People will base all their actions and reactions off of this foundation. “Sexuality is the core of human identity and personhood” (Harrison 2001: 70). Therefore “the need to understand the context of
young people’s sexuality and how they have been perceiving and responding to AIDS becomes clear” (Setel 1999: 19).

In many African societies, especially Maasai, the gender roles and sexual identity are very distinct. Males are the protectors, proprietors, and dominant figures, while females are the suppliers, reproducers, and rearing agent. The man is the controller while the female is the reproducer.

In Maasai culture as well as many other African cultures, men have all the power related to money, migration, production, etc... The male role is dominant. “Males impose stricter rules on their daughters or wives” (Caldwell 1997: 43). The female role is to accept the orders. A young South African stated very simply, “They have more power than us” (Harrison 2001: 74). Even in childhood differences in the chores the two sexes are assigned. These “differences in household roles and responsibilities ascribed to girls and boys have implications for women’s ability to communicate, make decision, and seek information and services throughout their life cycle” (Weiss 2000: 235). Through this socialization young women are taught to be submissive. Her tolerance will later make it difficult for her to try to negotiate safe sex. If the male is the dominating figure then he must control all household decisions. Therefore, “women have less bargaining power when it comes to sex” (Bitangaro 2001: 1). Would it then be possible for a female to suggest that a male use a condom? In the era of AIDS, “the pivotal role of gender is putting young women at risk” (Harrison 2001: 76).

Coerced sex is another aspect of gender roles and power related to HIV transmission. Rape is practiced prevalently throughout Africa. A study in Malawi found that more than “half of 168 sexually experienced adolescent girls in the Malawi said they had been forced to have sex” (Weiss 2000: 240). In a Nigeria study, “20.6% of 274 sexually active university women surveyed said they had been forced to have sex” (Weiss 2000: 240). The Oxford definition of rape is “the act of forcing a woman to have sexual intercourse against her will” (Pearsall & Trumble 2002:1196). Rape in Africa fits this definition, but it is hard to define where a woman’s will begins. Many African women are dependent on men for economic survival (cf. Lawson 1999: 398). This dependence does not allow them an option of refusing sex. If the sex is against
their will but they won't refuse because they want the man's support, is it rape? Because of these complications such assaults are significantly underreported. Whether or not these coerced acts are considered rape or simply socially pressured sex, they increase vulnerability for HIV transmission.

On the other hand, women do find power in their reproductive role. Maasai women experience sexual freedom within their culture, some even when married. This is partly due to the importance of reproduction (cf. Hodgson 2001: 35). The woman holds power in her fertility. A woman strives to have children with her husband or partner because it is through her children that she will gain security in food, housing, and money (cf. Setel 1999: 81). A man will at times feel more compelled to support his girlfriend if she has given birth to one or more of his children. How can condom use ever find a place where reproduction provides such significant power for the woman? If the female is the reproducing figure then she must have unprotected sexual intercourse to fulfill her role.

Furthermore, some women use their sexuality itself as power. "In many married relationships, for example, a woman looked upon sex not so much as a right of the male partner but as an exchangeable commodity to be used to obtain affection, to secure harmonious relationships at home, to achieve social status, and to obtain favors, benefits, and goods, both for herself and for her children" (Mane & Aggleton 2000: 111). The Maasai woman, as well, uses her body to work for the resources she needs to survive.

2.3 Westernization through Education

"The introduction of Christianity and Western education brought in new cultures and distorted the traditional African social norms and values that functioned as mechanisms for social, moral, and political control" (Lugalla 1999: 383). As more and more young Maasai women are being sent to school to obtain an education, they are also being exposed to new Western material goods. Especially during secondary boarding schools when young women are at a vulnerable developmental age, the desire to assimilate and fit in with their peers is very high. One way to demonstrate that they are able to assimilate is by acquiring the same Western materials as their peers. The methods for acquiring such materials are the same avenues mentioned
earlier in the discussion on poverty: through sexual relationships with older men. The only difference is in the materials motivating such relationships.

In boarding schools the girls no longer need clothes, flour, and sugar since they are required to wear uniforms and the boarding schools supply all the food. Instead the young women have sex to acquire the resources with which to purchase lotion, gumballs, and nail polish. If you ask Maasai girls in Narok what they need money for or what they buy, rural primary school girls will answer “clothes” and “food”. Urban secondary students will repeatedly list lotion as their number one answer.

Literature indicates that in many cases, the more education a women has the more skills she will have to avoid HIV transmission. In this instance, however, it is the education and its inspiration toward assimilation that fosters an increased risk for the virus. I have done a number of literature searches to find discussion about this emerging risk, but have yet to find any. Setel’s research in Tanzania, however, mentions the general effects material goods have had on risk behavior. “Tamaa [desire] entered our society when foreigners came; when Europeans brought material goods that weren’t known here—things like shoes, tables, cloth, plates, bowls, coasts, boots, forks, knives, blankets, mattresses, beds, cars, lamps, metal sheeting, pressure lamps, flat irons” (Setel 1999: 60). Westernization is changing many things in Maasai society, one of the most significant being those material goods that women deem necessary for survival.

2.4 Theoretical Background

In cross-cultural situations such as this, a medical anthropology approach is essential in discussions about the transmission of HIV/AIDS. It is essential to have a culturally relative perspective to understand the importance of specific values and social facts (cf. Durkheim 1895, Boas 1920).

Current HIV/AIDS interventions are designed and implemented from a Western perspective. “Early epidemiologic studies of the spread of AIDS in Africa started with the conventional wisdom about mobility and risk and ignored fertility issues altogether” (Setel 1999: 53). The premise behind interventions has been that people educated about the risks of contracting HIV may be expected to make behavioral changes necessary to prevent infection.
But this approach assumes that every person shares the same perspective about risk behaviors. The main risk behavior encouraging the spread of HIV throughout the world is sex. Sex and sexuality have many different meanings across different cultures. As Ross and Rapp stated, “Social definitions of sex may change rapidly and in the process transform the very experience of sex itself” (Ross & Rapp 1997: 153).

“Sexuality is the core of human identity and personhood” (Harrison 2001: 70). For Maasai women sex is an essential aspect of life. As one participant told me, “There is nothing in this world that has blood that does not enjoy and want sex” (Moja). So the question is, is sex enjoyable because of the physical pleasure or because of the results. The Western perspective would say because of the pleasure. In kinship based societies, however, such as the Maasai, the joy may come not only from the pleasure but also from results. Children are the reason for life. Family is why a Maasai lives.

I was fortunate enough to be present for the first few months of my friend’s baby boy’s life. He was born on May 7, 2004, and I arrived at her house on June 15, 2004. Since I was living on her homestead and was considered to be her eldest daughter, much of the care taking was left with me as the mother rested and recovered from childbirth. I had for some time understood that children were important to the Maasai way of life, but I now had the opportunity to witness this firsthand. There were days during which we had 3 to 5 visitors stop by to meet the new baby. Some people had walked more than 10 km to visit. Everyone was thrilled. Each person would spit on him, giving a blessing that means, “Do not be afraid of me.” This is the symbol that the visitor means no harm against the child. Then the visitor rubbed the child down in cow fat, singing songs all the while. This process went on for a few months until all of the family and most of the neighbors had been introduced. One thing became clear to me, watching this process. Children are the point of life. Any new member of the community was to be welcomed, received with open arms, and celebrated.

To review this cultural aspect from a critical medical anthropology perspective is to easily understand why current HIV/AIDS interventions are not working. The only
solution most interventions give people is to limit the partners with which you have sex. This type of intervention is trying to isolate sexual activity from the rest of the environment. The meaning and affects of sex must be considered in their full context. If a woman is only having sex with her husband she limits her chances of conceiving children.

If an intervention promotes action that erodes core life values for a specific population, what incentive do individuals have? Are they to abandon the meaning of life today for protection from a disease that will affect them 10 years later?

"In short, disease cannot simply be reduced to a pathological entity in nature but must be understood as the product of historically located sociopolitical processes" (Singer 1998: 229). An intervention must be holistic. It must consider all the elements of the environment a person lives in, social, sexual, political, and economic. It is only through a critical and comprehensive review of the entire situation along with the social relations involved that an effective, appropriate, and sustainable intervention will be designed (c.f. Singer 1998).

Maasai are a very well known and well studied society. For years researchers have been trying to understand the culture and then explain it through theories and literature. Many studies have tried to analyze a society and connect symbolic meanings behind the actions and customs. At times these analyses have actually lost the true word-for-word description given by participants in the beginning. Through my research I tried to listen to the views and perspectives my participants were telling me. I would then try to analyze those views within the structure of the culture itself and the surroundings they are currently set in (cf. Rosaldo 1989). The participants know what they feel. My job as a medical anthropologist is to understand those feelings within the contexts they are living in and analyze the total structure together with its influence on health.

With an applied anthropological research study the goal "is not to produce general theory but to solve problems" (Bennett 1996: S25, S28). The benefit of anthropology within the realm of HIV/AIDS is that ethnographic skills can be used to truly understand the behaviors and social facts that are contributing to the spread of the disease. "Most of the time intimate first hand knowledge of peoples and
communities and the discovery of culturally appropriate recommendations for ameliorating problems were the most important factors" (Ervin 2000: 7). Cultural information can influence AIDS interventions to be appropriate and effective.

2.5 AIDS and Anthropology

Anthropologists have been using their unique skills as cultural brokers in the fight against AIDS since the early 1980's. “In 1989, Medical Anthropology became the first journal in the field to devote an entire issue to anthropological research on the AIDS pandemic” (Bolton & Singer 1992: 1). In 1986 an interest group was formed out of the Society for Medical Anthropology; the AIDS and Anthropology Research Group has been active in connecting and engaging anthropologists working on AIDS issues. Around the world anthropologists have been working to help communities and policy makers alike understand the causes behind the spread of the disease. The solutions and interventions being designed from their research has followed one essential theme: “Prevention works best when it promotes change through individual and community empowerment strategies informed by holistic understanding of the local context” (Ibid.: 4). There are far too many anthropologists working on AIDS research to highlight in this text. Still, I would like to take the time to highlight a few findings from some studies that relate specifically to this research.

Ralph Bolton has done some valuable work on the AIDS epidemic among the gay community in the U. S. In one study Bolton examines the history of HIV/AIDS emergence in the gay community, how preventions were set up, and the effectiveness of such preventions. In the beginning, one of the few facts we knew about the transmission of the disease was that is was transmitted sexually. The U. S. government launched an enormous campaign to combat promiscuity and lower incidences of the disease, which has now been exported around the world. “Promiscuity has been deeply embedded in a number of AIDS public policy discussions, and sexual morality is often the basis for decision about legislation and funding on AIDS topics” (Bolton 1992: 16). Consequently, the CDC guidelines for prevention include major emphasis on abstinence and partner reduction. The media did not want to advertise condoms, so the overwhelming majority of social marketing focused on limiting the number of sexual partners. However limiting sexual partners
does not take into account that some of the partners could be HIV positive or unfaithful. "We know that transmission can occur at a single exposure, but we also know that the risk per exposure is rather low" (Bolton 1992: 46). Therefore if a person has a limited number of partners, but one of the partners is infected, then the risk of transmission may actually be higher than another person with numerous partners. So the argument in favor of simply reducing promiscuity is erroneous if people do not know the partners with whom they are sexually active. It has been proven that anti-promiscuity messages in the States do lead to a reduced number of partners. They were proven in the gay population of a specific region.

Nancy Romero-Daza recently presented her work on HIV/AIDS prevention programs in Costa Rica at the Society for Applied Anthropology meeting in Santa Fe, New Mexico April 7, 2005. During this program they recruited local women to participate in training and evaluation of HIV awareness materials. They received women’s feedback on current media, such as AIDS posters, and then had the women design alternative posters they felt were culturally appropriate. One example was a poster of a dog running around with a condom in his mouth. While the facilitator did not understand the message, all the local women considered this to be one of the best designs. It was later discovered that the Spanish word for dog was used in Costa Rica also as a reference to men who sleep around with other women. Romero-Daza’s project in Costa Rica is an excellent example of how culturally appropriate materials can be designed from the community up (cf. Romero-Daza 2004).

Douglas A. Feldman is an anthropologist who has been working on AIDS research from the beginning of the epidemic. Most of his work has been focused on the American Gay community and research in Sub-Saharan Africa. In all of his work he has emphasized the need for culturally-appropriate interventions. "We also know that AIDS is a preventable disease and culture-specific interventions can substantially reduce the future spread of AIDS throughout the world" (Feldman 1990: 6). Through his work in Rwanda Feldman identified the following factors to explain the increased heterosexual transmission rate throughout Africa: higher prevalence of viruses decreasing immune system and increasing likelihood of HIV transmission, higher
sexual activity and extramarital relations, and a higher prevalence of untreated STD’s increasing risk of HIV transmission (cf. Feldman 1990: 48-50).

Brooke Grundfest Schoepf is another anthropologist who has made significant contributions to AIDS research. Her work has been based in Zaire, Africa. From the beginning of the AIDS epidemic Schoepf and others realized that, “gender relations and sexual meanings are crucial to understanding HIV transmission and to developing effective disease control strategies” ( Schoepf 1992: 225). Ethnographic data has been used to understand sexuality, gender identity, international health, and governmental policies in Zaire. One community intervention/training looked at the roles that traditional African healers can play in intervention campaigns. The study used action-research with a local organization and held workshops with traditional healers to discuss sexual behavior and risk. “African healing methods and theory have not remained frozen in a timeless ethnographic present, but have changed and adapted with the times” (Ibid.: 232). They found that they could work with the healers to find new ways of interpreting medical facts and risks along with prevention options within their own traditional context that would be easily understood by the community.

This research project in Narok, Kenya intends to continue with the anthropological research on AIDS by using ethnography to understand perceptions, beliefs, behaviors, and other contributing factors putting Maasai women at risk for HIV/AIDS. Furthermore this research will use ethnography to examine and evaluate the current effectiveness of HIV interventions being used in the community.
Chapter 3

METHODS

Based on focus groups discussions with POH and the above literature review I chose to focus my research on three specific variables. The dependent variable in this research is: Maasai women have an increased risk for contracting HIV. There are three independent variables investigated during this research: sexuality, poverty, and education.

In order to answer the research question of why Maasai women are vulnerable to HIV/AIDS I used four different methods for triangulation (McNabb 1990). The methods used included demographic data collection, focus group discussion, nutritional anthropometric measurements, and in-depth interviews. The original sample area for the research was Kwanza, Kenya.

I lived in Kwanza village during my research from June to September 2004. My house was inside one of the homesteads in Kwanza. At this homestead I am considered the daughter of the female head of household. For this reason I was expected to perform all the roles a typical Maasai daughter would, i.e. cooking, cleaning, washing clothes, etc… This hands on participant observation gave me an insider’s look into the struggles women, young and old, face throughout their lives. Participants for the study were recruited during household visits in the community. Every household in the sample area was visited and given the opportunity to participate in the study, and 84% agreed. My original research design was to take place in Kwanza alone. However, POH decided that Kwanza was too small of a sample to represent Maasailand behaviors. Since this research will be used to develop a culturally appropriate intervention it was important to get a larger sample. Therefore, a second sample area was added to my research, Pili.

Kwanza is 10 km South of Narok Town, there are an estimated 170 community members in this area living in 20 households. I worked and spent time with most of the members of this village during my years living in Kenya. My work in the area of

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6 A pseudonym has been created for the name of the this village.
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HIV/AIDS was also well known. For Kwanza, the oldest son from my homestead acted as my guide and translator. He walked me from house to house and translated from Ki-Swahili to Ki-Maasai when necessary. Most households greeted me with excitement and wanted to help in any way they could. There were a few households that were hesitant but as my guide and I explained the project they became willing to participate. In the beginning, I assumed that it would be appropriate to explain that my research was connected with POH, and I pushed this aspect of my project. I then realized that it was more effective to explain the connection of my research to the university. In all cases, I explained both sponsors, but I realized the project had more credibility when I emphasized the university. Kenya has had so much donor assistance everywhere in the country that people are mistrusting of outsiders and outside organizations. They assume most people are trying to write proposals to get money. This is why the University turned out to be a more credible reference. Two households refused to participate in the study. The first claimed, “It is for kids. She will only sell the information, and what will I get out of it”. The second said “What will I get out of it, I don’t want anything to do with HIV/AIDS, lessons and awareness will do nothing without medicine. It is up to each person”. In Kwanza on the first visit I collected household demographic information and did interviews. On a later date, after securing the equipment, I went back to do nutritional anthropometric measurements.

Pili is another 10 km East of Narok Town. This village is split up into two sections, upper and lower. Since I did not know Pili very well, POH found a resident that could act as my key informant and guide. After our first meeting we discussed a schedule of field days along with the most efficient manner for collecting data at each household. Since I wanted the second sample to be of comparative size to the first, my informant suggested that we use lower Pili as the sample area because the entire village would be too large to cover. Lower Pili also has around 190 members living in 16 households. My informant suggested that we collect all the data in one visit, since this village was a 7 km walk from my home. On certain days an additional 20 km into

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8 I am fluent in the language Ki-Swahili, and have a basic grasp of Ki-Maasai.
the interior part of Pili, I agreed that making one visit would be the best solution. Therefore, in lower Pili the household visit started out with demographics, then nutritional measurements, and finally any possible in-depth interviews. I was also surprised to find I was well known in lower Pili, even though it was my first time visiting the area. They had heard of me from my years living in Narok. This fact in itself is the reason why they agreed to participate in my study. My guide for Pili mentioned that there is no way they would have agreed to participate if they had not already known of me and the work I had done. There was one household that refused to participate in the study, the male head of the household had been drinking and claimed, “This work is only a business”. His response again was referring to the now donor dependent culture in Kenya. Two other households were not included in the study simply because there were no residents home at the time of the field visit.

3.1 Demographics

I chose demographic data collection as one of my methods for two reasons; to look at the marital situation of young women and to acquire a locally defined socioeconomic (SES) status scale to rank households, understanding the source of income, food, water in households, and the kinship ties binding the households. The demographic data served as a background script while I coded and analyzed the in-depth interviews, which provided a holistic understanding of the situational environment that encourages risky sexual behavior.

Since poverty is a suggested factor that leads women to develop risky behavior I wanted to assess the SES in each of the households in my sample areas. I counted livestock and beads, two important indicators of wealth in Maasailand.

My culturally appropriate rankings of socio-economic status were used as a tool to code the interviews and analyze accordingly to risks women take in their lives. Appendix A is a sample of the form used to collect demographic information, on the back of this form a kinship chart was drawn for every household.

3.2 Nutritional Measurements

Literature shows a direct correlation between poverty and risk for HIV (cf. Ackermann 2002, Farmer 1996, Fenton 2004, Setel 1999). This is especially true for mothers. Throughout Narok there are hungry children, and behind most hungry
children is a mother trying to find them food. In many cases the mothers engage in risky sexual relationships in order to obtain food for their children.

Nutritional anthropometric measurements were taken in order to try to understand the link between the health of children and the behavior risks of the mothers. The original research design was to take measurement on girl secondary students. This design was changed when POH explained that secondary schools in the area were all boarding schools with food programs. POH wanted to see the measurements of the younger children since that is the most vulnerable age for malnutrition. We therefore agreed that I would take measurements on the children in their homes. A quota sample was taken of the children in the two villages to represent the entire population (Bernard 2002: 181). Two measurements were taken on children ranging from 2 months old to 17 years: height, and weight. Equipment for the measurements was borrowed from Center for Disease Control Kenya, a statometer manufactured by Shorr Productions and SECA scale manufactured for UNICEF. In total 95 measurements were taken on children in the 31 households in the sample areas.

Taking measurements gave validity to my research. I began the demographic data collection before I had obtained the nutritional measurement equipment. Doing the data collection without the equipment, people looked at me with suspicion and felt they were getting nothing out of participating. Once I had obtained the equipment and began taking measurements the scale itself validated my work. Everyone was excited to see their weight, and they felt this entertainment and knowledge was what they received in return for participating in the study. At my own boma the scale changed the dynamics and conversations during the evenings. One of the herder boys claimed one night “I am going to eat more ugali\(^9\) even if I am full, then Naserian will weigh me tomorrow to see if I have gained any kilos”. It was wonderful to see the thrill on people’s faces when they saw their own weight for the first time in their lives.

\(^9\) Ugali is the local staple food made out of corn meal.
3.3 *In depth Interviews*

Perceptions and roles of sexuality were measured through qualitative in-depth interviews of women residing in the two sample areas. It is important to understand the role of sex, sexuality, and sexual relationships if we are to try to understand what factors are placing young women at risk for exposure to HIV. Cross-generational interviews were done in order to get a comprehensive understanding of Maasai sexuality and how it plays out and is used in the culture. These interviews gave a comprehensive understanding of sexual difference in several age groups and new perceptions that are rising. Informants were recruited during household visits for demographic data collection. Women, young and old, who spoke Ki-Swahili, were asked if they would like to volunteer as participants. Since both of my guides were men, I decided to recruit only women who spoke Swahili so that I could conduct the sensitive interviews myself. Since sexuality is a sensitive topic, it was important that informants had strong rapport with me in order to gather in depth information on the topic; therefore I used purposive sampling (Bernard 2002: 183). Overall, 25 interviews were conducted. The following are some of the characteristics of the interviewees. Looking through the Table 1 it becomes obvious that interviewees were stratified across age groups, the two sample areas, between education levels, and traditional/western dress women.

**TABLE 1: Characteristics of In-depth Interviewees**

<table>
<thead>
<tr>
<th>ID</th>
<th>Age</th>
<th>Tribe</th>
<th>Marriage</th>
<th>Village</th>
<th>Education</th>
<th>Dress</th>
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<tbody>
<tr>
<td>Moja</td>
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<td>Maasai</td>
<td>Married</td>
<td>Kwanza</td>
<td>None</td>
<td>Traditional</td>
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<td>Mbili</td>
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<td>Maasai</td>
<td>Not</td>
<td>Kwanza</td>
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<td>Western</td>
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<td>Tatu</td>
<td>42</td>
<td>Maasai</td>
<td>Polygamous</td>
<td>Kwanza</td>
<td>None</td>
<td>Traditional</td>
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<td>Nne</td>
<td>32</td>
<td>Maasai</td>
<td>Polygamous</td>
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<td>Western</td>
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<td>Tano</td>
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<td>Maasai</td>
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<td>Sita</td>
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<td>Maasai</td>
<td>Not</td>
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<td>Saba</td>
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<td>Maasai</td>
<td>Not</td>
<td>Kwanza</td>
<td>C: Standard</td>
<td>Western</td>
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<td>Nane</td>
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<td>Polygamous</td>
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<td>20</td>
<td>Maasai</td>
<td>Polygamous</td>
<td>Kwanza</td>
<td>P: Standard</td>
<td>Traditional</td>
</tr>
<tr>
<td>Nabo</td>
<td>18</td>
<td>Maasai</td>
<td>Married</td>
<td>Kwanza</td>
<td>P: Standard</td>
<td>Western</td>
</tr>
</tbody>
</table>
The following are some sample questions that were used in the open ended in-depth interviews:

Tell me your wedding day?
Tell me about your education?
Tell me about your circumcision?
Tell me about sex?
What age do Maasai girls start having sex?
What happens if a Maasai girl gets pregnant?
Do Maasai women have boyfriends?
Where does a Maasai women get money from if she needs it?
How do people get AIDS?
How can you prevent getting AIDS?
What do Maasai feel about condom use?
Can you give me an example of someone who got AIDS?
Why do you think young girls having a higher rate of HIV/AIDS?
Where are the girls getting the disease from?
What do you think would help Maasai girls prevent HIV?

In the first interviews I tried to ask the question in a direct personal manner, such as ‘do you have boyfriends’. I soon realized I was going to have to change my approach. The questions were very direct and came too early in the interview. I therefore, switched my interview technique to a more informal structure. After

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Marital Status</th>
<th>Type of Marriage</th>
<th>Kwanza Type</th>
<th>Kwanza</th>
<th>Western Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are</td>
<td>31</td>
<td>Maasai</td>
<td>Not</td>
<td>Kwanza</td>
<td>C: Standard</td>
<td>Western</td>
</tr>
<tr>
<td>Uni</td>
<td>16</td>
<td>Maasai</td>
<td>Not</td>
<td>Kwanza</td>
<td>C: Standard</td>
<td>Western</td>
</tr>
<tr>
<td>Onguan</td>
<td>38</td>
<td>Maasai</td>
<td>Married</td>
<td>Kwanza</td>
<td>None</td>
<td>Traditional</td>
</tr>
<tr>
<td>Esyet</td>
<td>12</td>
<td>Maasai</td>
<td>Not</td>
<td>Kwanza</td>
<td>C: Standard</td>
<td>Western</td>
</tr>
<tr>
<td>Illay</td>
<td>43</td>
<td>Maasai</td>
<td>Widow</td>
<td>Pili</td>
<td>None</td>
<td>Traditional</td>
</tr>
<tr>
<td>Naapishana</td>
<td>22</td>
<td>1/2 Maasai, 1/2 Married</td>
<td>Pili</td>
<td>P: Standard</td>
<td>Western</td>
<td></td>
</tr>
<tr>
<td>Emyet</td>
<td>25</td>
<td>Maasai</td>
<td>Married</td>
<td>Pili</td>
<td>?</td>
<td>Western</td>
</tr>
<tr>
<td>Naudo</td>
<td>20</td>
<td>Maasai</td>
<td>Married</td>
<td>Pili</td>
<td>?</td>
<td>Western</td>
</tr>
<tr>
<td>Digatom</td>
<td>28</td>
<td>1/2 Maasai, 1/2 Married</td>
<td>Pili</td>
<td>?</td>
<td>Western</td>
<td></td>
</tr>
<tr>
<td>Tomon</td>
<td>25</td>
<td>Maasai</td>
<td>Not</td>
<td>Pili</td>
<td>?</td>
<td>Western</td>
</tr>
<tr>
<td>Ishirini</td>
<td>12</td>
<td>1/2 Maasai, 1/2 Not</td>
<td>Pili</td>
<td>C: Standard</td>
<td>Western</td>
<td></td>
</tr>
<tr>
<td>Thelathini</td>
<td>12</td>
<td>Maasai</td>
<td>Not</td>
<td>Pili</td>
<td>C: Standard</td>
<td>Western</td>
</tr>
<tr>
<td>Arobanne</td>
<td>22</td>
<td>Maasai</td>
<td>Married</td>
<td>Pili</td>
<td>P: Standard</td>
<td>Western</td>
</tr>
<tr>
<td>Hamsini</td>
<td>37</td>
<td>Maasai</td>
<td>Married</td>
<td>Pili</td>
<td>None</td>
<td>Traditional</td>
</tr>
</tbody>
</table>
obtaining verbal consent for the participation, I would simply ask the participant to tell me about the day they got married, or the day they were circumcised, or about school. I did not bring up any direct questions about AIDS until the last part of the interview. I originally was hoping that women would tell me about their risky situation or their sex lives. Participants took this type of specific questioning as though I was accusing them of having HIV. They assumed I was asking these questions because I believed they could have contracted the disease. In order to stop such perceptions I changed to asking questions indirectly. For example instead of ‘If you need food where do you get it?’, I asked ‘If a women is trying to find food where will she get it?’ (cf. Spradley 1997: 88) Women had the opportunity to answer freely without feeling like they were betraying their family trust.

3.4 Focus Group

One focus group discussion was held in Kwanza sample area. The questions for this open ended discussion were similar to the above interview questions. In total there were seven girls present, two of these young women were from Kwanza village while the other five where from another area. Also these same two young women currently attend an urban secondary school while the others go to a rural primary school. This diverse stratification led to some very interesting and important discoveries about the current perceptions young women have about HIV/AIDS. The following are the individual characteristics of the participants in the focus group discussion. The stratification of the participants can be seen across the age groups and educational level.

**TABLE 2: Characteristics of Focus Group Participants**

<table>
<thead>
<tr>
<th>Pseudonyms</th>
<th>Age</th>
<th>Village</th>
<th>Education</th>
<th>Grade Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Msichana</td>
<td>17</td>
<td>Kwanza</td>
<td>Secondary- urban</td>
<td>Form 3</td>
</tr>
<tr>
<td>Mtoto</td>
<td>11</td>
<td>Mfano</td>
<td>Primary- rural</td>
<td>Standard 5</td>
</tr>
<tr>
<td>Bidii</td>
<td>16</td>
<td>Mfano</td>
<td>Primary- rural</td>
<td>Standard 8</td>
</tr>
<tr>
<td>Kidogo</td>
<td>14</td>
<td>Mfano</td>
<td>Primary- rural</td>
<td>Standard 8</td>
</tr>
<tr>
<td>Kitoto</td>
<td>11</td>
<td>Mfano</td>
<td>Primary- rural</td>
<td>Standard 6</td>
</tr>
<tr>
<td>Mwanafunzi</td>
<td>17</td>
<td>Mfano</td>
<td>Primary- rural</td>
<td>Standard 7</td>
</tr>
<tr>
<td>Mbili</td>
<td>17</td>
<td>Kwanza</td>
<td>Secondary- urban</td>
<td>Form 1</td>
</tr>
</tbody>
</table>
3.5 Qualitative Interviews and Analysis

All in-depth interviews and the focus group discussion contained a portion of HIV counselling at the end. Once the interview questions were asked, I gave participants time to ask me any questions they may have had about HIV/AIDS. Many women do not have access to a confidential source to ask questions about this disease, and these small counselling lessons were a payment for participating in the interview. Many questions surrounded modes of transmission, prevention, and HIV testing.

Interviews were recorded using a Sony digital recorder. There was only one participant who refused to be recorded, and in that case notes were taken during the interview. It may be that she refused to be recorded because another woman in her household had been sick with what she thought was AIDS. I then translated and transcribed all recorded interviews upon my return to Oregon. Once a full text document was available, the software NVIVO was used to code and analyze the transcriptions for reoccurring themes.

3.6 Participant Observation

Participant observation notes became an important component of my research. Because of my role as a member of the community I was given the opportunity to truly understand the lives and struggles of Maasai women. As a trusted member of the community, I was privy to information about many of the other community members. There were a number of instances were information given to me in a personal interview could be crosschecked with information from the community.

3.7 Reflexivity

As mentioned earlier I was considered the daughter of the bomas where I lived throughout this research. The female head of the household had been my first and closest friend since 2000. The two of us became a well known pair walking around Narok Town. If someone saw me without her, the first question would be about where she was. Many times people gave her a hard time for being so close to me. They

---

10 The woman my participant was referring to died in the hospital on 2/25/04
would either assume she was rich since she ‘walked town with a white girl’. Or they knew she wasn’t rich and questioned why she spent so much time with me. The answer? We were instant friends, cross cultural difference aside “Tunasikelizana na roho” (We hear each other with our souls).

While being a daughter of a woman in the village certainly helped legitimized my research, it was an extremely hard personal adjustment. However close I had been to my friend I had never lived in the same household with her. As her daughter living in her household expectations were more intense. A Maasai daughter has many household duties. It was assumed that I would cook all the food for the 6-8 members of the household each day, wash all the dishes, wash the babies’ clothes, and assist with milking the cows and collecting firewood. (Although the last two I never perfected, so I was almost discouraged from doing these chores). I remember at one point getting frustrated in the evening as I was trying to get the food prepared to cook dinner, I kept thinking how long will this last? And then my friend looked at me and said ‘you look tired, let me help you tonight with your work’. It was at that point that I realized this was now ‘my work’, these were my expectations day in and out for the entire time I lived there.

While planning my time frame within the research design I had not calculated day long household chores. At times I would finish washing the morning tea dishes and try to escape to write in my field notebook, I would not be gone for more than 15 minutes before I was called back to do something else. Needless to say the first few weeks were very frustrating. I never found a way to change these expectations, but I reached a better understanding of them.

Most Kenyans feel that to be alone is a negative thing. A person is alone only if they are sick; otherwise they should always be surrounded by friends and loved ones. When I tried to go off alone to write, my friend would be concerned for me. She would call me back to do some other work so that I would be surrounded by people and not alone. Later on I realized that if I explained I needed to write up my research she would understand and respect that requirement. The second understanding was simply that these responsibilities were placed on me because I was truly considered family. It is one thing to say I was thought of as a daughter; it is an entirely different
thing to actually be treated as a daughter through love and required duties. Slowly as the weeks passed I got used to the household work load and how to find a balance between home and field work.

An unexpected benefit of doing the household chores came from the perspectives of other village members. Community members that came to visit our home saw me in the daughter's role: cooking, serving tea, serving food, washing dishes. Afterwards when I would visit their households they had respect for me as a fellow community member, because they had not only heard I was considered a local daughter, they saw me with their own eyes in that role. This personal knowledge led to a deeper respect for me as a person and the research I was doing.

While my relationship with the community has been an incredibly positive and beneficial influence in my life and research, there has been however some emotional stress due to these relationships. We still do not know the actual rates of HIV in this area since only a few people have been tested. However I have seen the effects of the disease over several years. I have watched people get sick, some friends I know are HIV positive, and others that have died of this disease. Watching people die of AIDS is an extremely hard process, especially in a developing country with little access to health care or even pain killers. The entire process can take up to two years. The person gets sick, spends meager financial resources to get medicine, gets better for a month or two and then gets sick again. It is a long excruciating death. Watching friends and family go through this tears my heart out.

As my relationships in the community grew, the more details I would hear about specific people's lives and behaviors. The hardest thing for me to understand was how so many men could see these deaths, know the cause, and still refuse to change their behavior. The following three examples come straight from my sample areas. One man, who knows he is HIV positive, yet is still involved in multiple sexual relationships outside of his wives, none of them knowing his status. Another case is an HIV educator who was away from his wife, living in another rural area to set up an HIV awareness youth club. He got a 17 year old girl pregnant. A third case was a husband of a participant who asked me to have sex with him just before I interviewed his wife. In the interview the wife explained that they prevented AIDS by being
faithful. As time went on and I was actually exposed to the sexual behaviors I became overwhelmed with frustration. I would try to remember that the sexual norms of this culture are different from my own. My job as an anthropologist was to try to understand these norms and the effect they have on HIV/AIDS transmission, not to judge the men for their behaviors. However, woman after woman explained to me they were worried about AIDS but could not talk to their husbands or boyfriends about their affairs for fear of being beaten up. They could not leave their husband because their children would starve. I was left in despair. Many days when I felt so overwhelmed by these feelings of inevitability, I just sat and cried.

The hardest part of fieldwork was when I explained my research and some people looked at me with such hope and light in their eyes. It is in these moments I felt helpless and guilty for giving them the idea that my research may actually make a difference. Through these overwhelming feelings of doubt I continued on with the field work, as much as I continue today through the analysis. I do keep a small reserve of hope that my findings and recommendations could possibly shine a little light on the situation.

3.8 Limitations

There are two major limitations to this study; gender of participants and reference to behaviors. I had only female participants. This is due to the strict gender roles in Maasai society. Women do not interact with men in depth except sexually. A friend of the opposite sex can only mean a friend with whom that you have sexual relations. Many times women and men eat seperately. Because of these strict roles it would have been inappropriate for me, as a women, to conduct a one-on-one in depth interview with men. It is for this reason that my participants for the qualitative interviews were all women. The absense of male participants is a weakness in the study, especially in regard to HIV/AIDS transmission. Women told me over and over again about behavior risks they take to please the men in their lives. A truly holistic study and intervention needs to have the other gender included. It is clear that I cannot be the researcher in this other half of the study, as my relationship with the community places me in the same expected gender role as other women. However, this research can be looked at as the beginning of understanding risky behavior.
Another limitation to the study is the specific references to behavior risks. During my years living in Narok, friends had explained to me their sexual relationships with different men in town. I was assuming I would be able to go back and get the same in depth descriptions; however, I was proved wrong. The same friends that explained their relationships with boyfriends were now denying such relationships. There may be several reasons for their change in openness. It could be that my stay was too short to regain such rapport, or that women were reluctant to have such information recorded, or because the research was about HIV/AIDS. Acknowledgement of their behavior would have been the same as admitting they could have AIDS. I do not know the exact reason for the difference, but it was there. This became a limitation because I could not directly link women’s risky behavior to their socioeconomic status or the nutritional health of their children.

3.9 Human Subjects

This research was approved by the Oregon State University Human Subjects Institutional Review Board, application number 2524. This study was fully explained to potential participants. After a full explanation and all questions answered, an oral consent was obtained for inclusion of the study. Due to the high rate of illiteracy it was agreed with IRB that oral consent was the best method to use. All participation in this project was on a voluntary basis only. Data collected with this research will remain confidential. All names and location in this thesis have been given pseudonyms for protection of my participants. See Appendix B for the IRB approved oral informed consent form that was used during research.
Chapter 4

RESULTS

4.1 Demographics

The Kwanza village consisted of 15 households, and the Pili village 16 households. While the sample size of this study is not large enough to generalize about the socioeconomic status of all Maasai in Narok, the data gives necessary background for analyzing the interviews. Table 3 gives a breakdown of the number of residents in the sample area and an average number of people per household. The table also breaks down the type of household members. There were a total of 354 people included in this study.

<table>
<thead>
<tr>
<th>Household Members</th>
<th>Sample Size-Offspring</th>
<th>Sample Size-Dependents</th>
<th>Sample Size-Men</th>
<th>Sample Size-Women</th>
<th>Sample Size-Wives</th>
<th>Sample Size-Extended Family</th>
<th>Sample Size-Total</th>
<th>Average per Household-Offspring</th>
<th>Average per Household-Dependents</th>
<th>Average per Household-Men</th>
<th>Average per Household-Women</th>
<th>Average Per Household-Wives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offspring</td>
<td>102</td>
<td>99</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>201</td>
<td>6.3</td>
<td>6.18</td>
<td>6.28</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependents</td>
<td>19</td>
<td>7</td>
<td>27</td>
<td></td>
<td></td>
<td></td>
<td>1.18</td>
<td>1.18</td>
<td>.44</td>
<td>.84</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>22</td>
<td>31</td>
<td>53</td>
<td></td>
<td></td>
<td></td>
<td>1.3</td>
<td>1.3</td>
<td>1.94</td>
<td>1.65</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>33</td>
<td>41</td>
<td>74</td>
<td></td>
<td></td>
<td></td>
<td>2.06</td>
<td>2.06</td>
<td>2.56</td>
<td>2.31</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wives</td>
<td>20</td>
<td>20</td>
<td>49</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td>2</td>
<td>1.25</td>
<td>1.53</td>
<td>1.53</td>
<td></td>
</tr>
<tr>
<td>Extended Family</td>
<td>9</td>
<td>15</td>
<td>24</td>
<td></td>
<td></td>
<td></td>
<td>.5</td>
<td>.5</td>
<td>.94</td>
<td>.75</td>
<td>.75</td>
<td></td>
</tr>
<tr>
<td>Total People</td>
<td>172</td>
<td>182</td>
<td>354</td>
<td></td>
<td></td>
<td></td>
<td>10.75</td>
<td>11.3</td>
<td>11.06</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Most households were located on 20 to 40 acres plot of land. Pili households were closer to each other than Kwanza households. Traditional Maasai houses are made entirely out of the mud (n=3), however a majority of houses now have mud walls with corrugated iron roofs (n=26) in these two sample areas. There were two houses made out of wood, and both of these households located in Pili were either a

---

11 Offspring is the number of total children in the household.
12 Dependents are children in the household who are not offspring, usually herdors or orphans.
13 Men is defined as any male over 21 years old.
14 Women includes wives, as well as widows and grandmothers.
mix of Maasai and Kikuyu tribe, or solely Kikuyu. The total number of houses with Kikuyu residents in the sample areas was six. There is more Kikuyu influence in Pili since it is closer to town. The Kikuyu tribe is known throughout Kenya for their business ability. In the past decade the migration of the Kikuyu tribe to Narok Town has increased because of the business opportunities there. Maasai residents have sold small plots to them close to town, which is why there were some Kikuyu residents in Pili. Most of the Kikuyu households also participated in agriculture, the majority growing beans and corn. The socioeconomic status was measured through cultural defined objects of value. All cows, goats, sheep, milk, and beaded necklaces were counted to establish socioeconomic status. The significance of these items is explained below. Table 4 give a breakdown of household characteristics.

**TABLE 4: Demographics of Households**

<table>
<thead>
<tr>
<th>ID</th>
<th>Tribe</th>
<th>House Material</th>
<th>Pit Latrine</th>
<th># cows</th>
<th># goats &amp; sheep</th>
<th>Milk (liters per day)</th>
<th>Beaded Necklac</th>
<th>Farming</th>
</tr>
</thead>
<tbody>
<tr>
<td>N1</td>
<td>M</td>
<td>Mabati</td>
<td>None</td>
<td>49</td>
<td>65</td>
<td>5</td>
<td>13</td>
<td>Corn, Beans</td>
</tr>
<tr>
<td>N10</td>
<td>M</td>
<td>Mabati</td>
<td>None</td>
<td>20</td>
<td>20</td>
<td>5</td>
<td>10</td>
<td>Corn, Beans</td>
</tr>
<tr>
<td>N11</td>
<td>M</td>
<td>Mix</td>
<td>None</td>
<td>7</td>
<td>10</td>
<td>1</td>
<td>9</td>
<td>Corn</td>
</tr>
<tr>
<td>N12</td>
<td>M</td>
<td>Mix</td>
<td>None</td>
<td>12</td>
<td>20</td>
<td>1</td>
<td>3</td>
<td>Corn</td>
</tr>
<tr>
<td>N13</td>
<td>M</td>
<td>Mabati</td>
<td>None</td>
<td>0</td>
<td>18</td>
<td>0</td>
<td>14</td>
<td>Corn</td>
</tr>
<tr>
<td>N14</td>
<td>M</td>
<td>Mabati</td>
<td>None</td>
<td>72</td>
<td>112</td>
<td>4, 1 sold</td>
<td>10</td>
<td>Corn, Beans</td>
</tr>
<tr>
<td>N16</td>
<td>M</td>
<td>Mabati</td>
<td>Yes</td>
<td>156</td>
<td>543</td>
<td>5</td>
<td>14</td>
<td>Corn, Beans</td>
</tr>
<tr>
<td>N2a</td>
<td>M</td>
<td>Mabati</td>
<td>Yes</td>
<td>156</td>
<td>543</td>
<td>7</td>
<td>20</td>
<td>Corn, Beans</td>
</tr>
<tr>
<td>N2b</td>
<td>M</td>
<td>Mabati</td>
<td>None</td>
<td>12</td>
<td>100</td>
<td>3, 2 sold</td>
<td>6</td>
<td>Corn, Beans</td>
</tr>
<tr>
<td>N3</td>
<td>M</td>
<td>Mabati</td>
<td>None</td>
<td>20</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>None</td>
</tr>
<tr>
<td>N4</td>
<td>M</td>
<td>Mix</td>
<td>None</td>
<td>38</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>Corn, Beans</td>
</tr>
<tr>
<td>N5</td>
<td>M</td>
<td>Mix</td>
<td>None</td>
<td>30</td>
<td>150</td>
<td>5, 2 sold</td>
<td>10</td>
<td>Corn, Beans</td>
</tr>
<tr>
<td>N6</td>
<td>M</td>
<td>Mabati</td>
<td>None</td>
<td>20</td>
<td>4</td>
<td>2</td>
<td>7</td>
<td>None</td>
</tr>
<tr>
<td>N7</td>
<td>M</td>
<td>Mud</td>
<td>None</td>
<td>10</td>
<td>33</td>
<td>5</td>
<td>2</td>
<td>Corn, Beans</td>
</tr>
<tr>
<td>N8</td>
<td>M</td>
<td>Mabati</td>
<td>None</td>
<td>30</td>
<td>60</td>
<td>10</td>
<td>5</td>
<td>Corn, Beans</td>
</tr>
<tr>
<td>N9</td>
<td>M</td>
<td>Mabati</td>
<td>None</td>
<td>17</td>
<td>50</td>
<td>4, 2 sold</td>
<td>7</td>
<td>Corn, Beans</td>
</tr>
<tr>
<td>P1</td>
<td>M</td>
<td>Mix</td>
<td>None</td>
<td>5</td>
<td>50</td>
<td>1</td>
<td>1</td>
<td>None</td>
</tr>
<tr>
<td>P10</td>
<td>M</td>
<td>Mix</td>
<td>None</td>
<td>20</td>
<td>70</td>
<td>6, 5 sold</td>
<td>3</td>
<td>Corn, Beans</td>
</tr>
<tr>
<td>P11</td>
<td>M</td>
<td>Mix</td>
<td>None</td>
<td>25</td>
<td>20</td>
<td>2, 1 sold</td>
<td>3</td>
<td>Corn, Beans</td>
</tr>
<tr>
<td>P12</td>
<td>M</td>
<td>Mix</td>
<td>None</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>Corn, Beans</td>
</tr>
</tbody>
</table>

---

15 It is important to understand that the measurements used in this study are culturally appropriate for the Maasai, the Kikuyu families can not fit into the these categories since they do not value cows or beads in the same manner as the Maasai.

16 Maasai

17 Iron Roof

18 Mud and Iron Roof

19 Maasai and Kikuyu residents
For Maasai, cows are the most important indicator of wealth. They are the Maasai bank. You buy a cow today, take care of it, it will have calves, and your bank account continues to grow. The idea is to conserve your cows, then in an emergency (e.g. draught, family member gets sick, or school fee debt) you have the cows to sell for money. People expend an enormous amount of physical effort and economic investment in cows. For instance, during times of drought the herders will travel over 50 km to insure that the cows have access to water and grass. Maasai also practice burning during drought to force the growth of new grass for the cows nutritional benefit. They spend a large amount of money on insecticides to insure the herd’s health, giving vaccines to the cows and washing the cows in insecticidal shampoo throughout the year. Quality of cows determines the status of a man. A man with the most wives and cows would have the highest status available in Maasai society. Both the cows and wives must be healthy. A Maasai man who has adopted a western lifestyle may have thousands of kenyan shillings, more than anyone has ever dreamed of, but if he has no cows, he would have the lowest status of society.

The average household in these two sample areas had 22 cows, the largest herd was 156 while the smallest herd owned by a Maasai was 2. Some households that did not have any cows were still classified as higher economic status because three of them included members that were of the Kikuyu tribe. As already mentioned, Kiuyu do not place the same value on cows: they place more emphasis on household structure and household goods. One of the lowest socioeconomic status households in the sample areas had no cows, however, in this household the wife was in charge of the entire household and she earned money from farming and brewing traditional beer.

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Kikuyu residents
The richest household in the entire study owned 156 cows. This household was also one of five that had a pit latrine in the homestead. The remaining four all had Kikuyu members in the household. While a pit latrine has been shown to lower many communicable diseases, this is not a priority for Maasai at this point. Building a pit latrine is an expensive project because you must hire a professional technicians to come dig the 30 foot hole. The cost can be as high as $250. When I hear women talk about what things they would want to improve their lifestyle, the first things mentioned are a water tank, and iron roofs, and furniture. I have never heard any plans of anyone building a pit latrine.

While cows are one of the strongest indicators of wealth for men, it is not necessarily wealth that women may benefit from. To begin with it is important to understand that Maasai women do not have their own status in society; their status is linked to their husbands. However, for this project I wanted to find a way to measure the women’s access to wealth. Since a wife does not have the ability to sell any of her husbands cows, that would not work as an indicator.

It is important to recognize while many studies establish a socioeconomic status for a household and target the risks for that household from the status, many households actually have multiple socioeconomic statuses. I wanted to look at the separate status of women in a household in order to understand their access to resources. I chose the two things that are important to women as a measure of their socioeconomic status: beads and milk. Beads are the women's equivalent to cows for men. A woman’s beads are something worn everyday so that people will recognize her wealth. Beads are her pride and joy. A woman acquires beads in a number of ways: at her wedding, from friends, from family, and most importantly from her husband. This was one indicator that could show access to money. At first I was not sure how to actually count the beads, and after talking to several women I quickly settled on counting a woman’s long beaded necklaces, called engoboli, these are the long necklaces that are wrapped once around the neck and then hang down a woman’s chest. On average a woman had 4 necklaces. There were 5 women that did not have any; however 4 of these were of the Kikuyu tribe. The one Maasai woman that did not
have any necklaces lived in a very low socioeconomic status homestead that owned only 2 cows.

The other measurement used for women was milk. A woman does not have any control over the sale of cows, however she does have control over the milk. A Maasai woman's first job every morning is to milk all the cows. She is then responsible for cooking and serving the milk or tea with milk. In many situations the women will split the milk and cook half, while selling the other half. This is the one of the few outlets for earning her own money that is approved by the husband. The average household at the time of data collection was milking about 3.5 liters of milk each day. This amount varies throughout the year depending on the rainfall and health of the cows. There were six households that had no milk. These are the six households owing few cows. Four of them were Kikuyu and two were the lower status Maasai homesteads.

4.2 Nutritional Measurements

All children living in the households and present during the homestead visits were measured. In some instances these children were not the offspring of the household adults due the common practice of child fostering. Child fostering in Maasai community is the practice of children being raised in households other than those of their biological parents (cf. Shell-Duncan 2000: 187). There are number of reasons why a child moves to live in other households or households of extended family: to help care for younger children in the house, to help care for the livestock, or to give an infertile women a child to care for. Table 5 shows a breakdown by age groups of all the children measured in this study.

TABLE 5: Age breakdown of the 73 children measured with WHZ scores

<table>
<thead>
<tr>
<th></th>
<th>&lt;1</th>
<th>1 yr</th>
<th>2 yr</th>
<th>3 yr</th>
<th>4 yr</th>
<th>5 yr</th>
<th>6 yr</th>
<th>7 yr</th>
<th>8 yr</th>
<th>9 yr</th>
<th>10 yr</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
<td>M</td>
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<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
<td>M</td>
</tr>
<tr>
<td>Pili</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>2</td>
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</tr>
<tr>
<td></td>
<td>6</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Sub-total</td>
<td>10</td>
<td>9</td>
<td>12</td>
<td>8</td>
<td>5</td>
<td>9</td>
<td>7</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Kwanza</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>sub-total</td>
<td>7</td>
<td>5</td>
<td>12</td>
<td>8</td>
<td>5</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>9</td>
<td>12</td>
<td>8</td>
<td>5</td>
<td>9</td>
<td>7</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
One of the biggest struggles in doing anthropometric fieldwork in this area was trying to ascertain the exact age of the children. In many cases the age recorded was a guess by one of the adults or siblings in the household. Having many participants who do not know when they were born is not uncommon in developing countries (c.f. Shell-Duncan 2000: 193). Lack of attention to chronological age reflects values in a community based society. Such societies have a strong social network involving all members of the community, not limited to an individual family. In Narok the age of a person is only important in relational context. For Maasai, age is a very important aspect of life, but the number of years a person has been alive is not important. The importance is in the designation of age-groups encompassing a five year span. Therefore when you ask about age, the answer often times is a comparison another person else or the age group. People place no value on remembering chronological age for each person. The school system now requires a child to know their age in years; however there are still many community members encountered in this study who did not know their own age or the age of their children. Consistent with similar studies I will analyze, only weight and height scores in the results section.

The World Health Organization (WHO) recommends the US data set from the National Center for Health Statistics (NCHS) as a standard international comparison of growth rates (WHO 1986). All weight and height measurements were entered into EPI-NUT, a software program of the Centers for Disease Control and Prevention, to calculate the standard deviation (Z score) from the NCHS.

The literature agrees that the standard interpretation of measurements is as follows (c.f. Mascie-Taylor 1991, Central Bureaus of Statistics (CBS) [Kenya] 2004, Panter-Brick 1998, etc.):

- Height-for-Age (stunting) HAZ
- Weight-for-Height (wasting) WHZ
- Weight-for-Age (underweight) WAZ
The typical breakdown of analyzing Z scores is as follows (Mascie 1991: 60):

- $> +1$ Over nourished
- $-1$ to $+1$ Adequately nourished
- $-2$ to $-1$ Mild undernourishment
- $-2$ to $-3$ Severely undernourished

Figure 4 shows the average WHZ score per age group in each sample area.

**FIGURE 4: Graph of WHZ scores**

The 2003 Kenya Demographic and Health Survey published national WHZ scores across Kenya for ages 1-5. These national scores are compared in figure 5 to the total sample in this study. The Narok scores rate higher in the first year than the national scores, and then afterwards they rate lower. This is probably due to two factors: after the second year children are weaned from breast feeding and the daily administering of cow fat decreases.
4.3 Diet

The Maasai diet traditionally consists of blood, milk, and meat. As Westernization and agriculture have been introduced to the Maasai their diet has changed. Today the average diet consists of milk, *ugali*, rice, potatoe, beans, green kale, and the occasional meat. Maasai are a pastoralist community and usually do prefer meat. However, meat is not consumed daily. In fact a slaughter happens only for special occasions such as giving birth, weddings, circumcisions, celebrations, or drought. Milk and *ugali* are the two largest components of a Maasai diet. *Ugali* is eaten almost daily, and milk is drunk either fresh, fermented, or in tea. *Ugali* is made from ground up corn flour. In thirty-one households (93%) grew corn, and (74%) grew beans. Only two households did not farm. Milk comes from livestock. Each household produces 2.5 liters per day. Surprisingly only nine of those households sell milk to increase income.

Infants have a specific diet. One-month old children and older infants are fed cow fat and herbs in order to increase their body mass and keep them in a robust health. The herbs are local medicinal plants mixed with cows milk. The fat is fed to the baby daily by hand. This intensive feeding process continues for most of the first year. Parents continue to prepare cow fat mixed with milk or herbs for their older children, although not as often as for infants. If the child is going off to school, has been sick, or has been circumcised the parent will most times feed them cow fat to increase their weight and health.
4.4 OTHER Z SCORES

As already stated, the ages reported for the children in this study were not dependable enough to use reliably in calculating results. Thus the results below must be considered as approximate indicators. The WHZ scores show that most of the children were adequately nourished, between 0 to -1. However this result does not necessarily conclude that these children were entirely healthy. When the estimated age of the children is added into the analysis calculating HAZ and WAZ scores, over 40% of the Z scores show scores between -2 to -1, which indicates mild undernourishment. The nourishment level may be worse than the WHZ score suggests, however it cannot be determined at this time because of the unreliable ages. See Table 6 for all of the scores listed together.

TABLE 6: Total measurements and Z scores

<table>
<thead>
<tr>
<th>Age (Years)</th>
<th>N</th>
<th>Mean Age (Years)</th>
<th>Weight (kg)</th>
<th>Height (cm)</th>
<th>HAZ</th>
<th>WHZ</th>
<th>WAZ</th>
<th>BMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.1-0.9</td>
<td>10</td>
<td>.37</td>
<td>6.27</td>
<td>58.50</td>
<td>-.078</td>
<td>1.57</td>
<td>0.91</td>
<td>n/a</td>
</tr>
<tr>
<td>1.0-1.9</td>
<td>9</td>
<td>1.08</td>
<td>8.68</td>
<td>68</td>
<td>-.95</td>
<td>-.32</td>
<td>-.99</td>
<td>n/a</td>
</tr>
<tr>
<td>2.0-2.9</td>
<td>12</td>
<td>2.3</td>
<td>11.19</td>
<td>82.08</td>
<td>-.80</td>
<td>-.71</td>
<td>-1.18</td>
<td>15.33</td>
</tr>
<tr>
<td>3.0-3.9</td>
<td>8</td>
<td>3.19</td>
<td>12</td>
<td>89.56</td>
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<td>-.96</td>
<td>-1.76</td>
<td>14.90</td>
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<td>14.80</td>
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<td>-0.68</td>
<td>-1.07</td>
<td>14.52</td>
</tr>
<tr>
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<td>15.61</td>
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<td>14.59</td>
</tr>
<tr>
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<td>6.07</td>
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<td>109.71</td>
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<td>-1.15</td>
<td>-1.48</td>
<td>13.70</td>
</tr>
<tr>
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<td>19.87</td>
<td>120.25</td>
<td>-0.41</td>
<td>-1.27</td>
<td>-1.14</td>
<td>13.75</td>
</tr>
<tr>
<td>8.0-8.9</td>
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<td>22.50</td>
<td>123.50</td>
<td>-0.73</td>
<td>-1.00</td>
<td>-1.12</td>
<td>14.30</td>
</tr>
<tr>
<td>9.0-9.9</td>
<td>2</td>
<td>9.00</td>
<td>18.10</td>
<td>113.75</td>
<td>-2.85</td>
<td>-0.96</td>
<td>-2.38</td>
<td>14.00</td>
</tr>
<tr>
<td>10.0-10.9</td>
<td>3</td>
<td>10.00</td>
<td>27.83</td>
<td>131.83</td>
<td>-0.95</td>
<td>-0.32</td>
<td>-0.89</td>
<td>15.83</td>
</tr>
</tbody>
</table>

The original goal of including anthropometry in this research was to find a link between the nutritional status of children and the sexual risk behavior of the mothers. A direct link was not able to be established because of the format of the interviews. Questions had to be asked in an indirect manner. This means that I was able to
establish indirectly that the child’s nutritional health does indeed affect a mother’s sexual behavior; however I could not link individual children and the mother’s interviews. The anthropometric information was merely used as another background script for analyzing the stress mothers go through in finding ways to feed their hungry children.

Women talked a lot about obtaining food in their interviews. They discussed the ways they would obtain the food and their struggles with hunger. “I slept hungry. And again I go in the morning, to look for food. I cook. These days it is better. Long ago I was bad. I was so black, black completely because of no food. I got milk, corn, meat” (Illay). This participant was speaking of the days after her husband was killed by an elephant. Later she found a boyfriend and things became easier because he brought her food. Several women used the phrase “begging for mercy” referring to their children’s hunger. They told me you find a way to help the children when they are “begging for mercy”. There are some very hungry children in the sample area. Having boyfriends can help obtain food for them.
Chapter 5

QUALITATIVE RESULTS

The following section will review the overall findings from the coding of in-depth interviews and focus group discussions. Themes were compared across all transcripts and the main reoccurring themes will be discussed below.

5.1 Knowledge of HIV/AIDS

Every one of my participants was knowledgeable about HIV/AIDS. The extent of their knowledge varied across demographics, mainly age and education. All had heard of AIDS, knew it was a deadly disease, and knew many of the modes of transmission. “To have sex, or if a person gets cut, and he puts blood in your body, you can get it” (Saba). Part of the reason why AIDS is now talked about so freely is its increased prevalence. You can rarely find a person who does not know of someone who either has AIDS or has died from it. “Many are dying, and they leave the kids. Baba and Mama are dying, and they leave the kids. Or Mama, and Baba, and the kids die” (Sita).

Along with the increased communication about HIV/AIDS comes an increased amount of gossiping. People are watching and wondering who has AIDS. If you become sick at all or lose any weight you are labeled as HIV positive, “If you become sick, they will say it is that” (Mbili). “I see the people who don’t have a good look. They loss weight, they have the things, cuts on their skin” (Tisa). Another new identification marker some women are using is the symbol of breastfeeding. The doctors at the hospitals test women in the maternity ward, but never tell the women they have been tested. If the woman is positive then the doctor will tell her not to breastfeed, but will not give a reason. Everyone now knows that if she is positive, a mother can’t breastfeed her child. Not breastfeeding a child has become another stigmatizing marker for women who have HIV/AIDS.

While the knowledge of HIV/AIDS was high, modes of prevention were still not used. I asked about condom use in every interview. I was trying to understand the women’s reactions and perceptions of condoms, and what men had told them about
condoms. They told me what took place at the ceremonial manyatta in 2004. POH went to the manyatta to do an HIV/AIDS awareness session. POH divided people by gender and age and showed them AIDS videos, and talked about transmission and prevention.

_Ehhh_\textsuperscript{21}. They are afraid of that disease. They watched, and watched a whole person, and he is like this tree, what do you do? Many people were just holding their mouth. The don’t go around so much these days. I don’t know if it came in a long time ago, or if it came in just the other day. These people. We are completely afraid. We were talked to with all of our children. And they brought condoms. (Naapishana)

Naapishana talked about how fearful these people were of the disease. When I asked her what they thought of the condoms, she laughed and told me they burned them. “Ehhh, they burned them. And if you stand still, they say that thing is for thieves. Just stay with god. This disease is entering all people, and what will you really do” (Naapishana). After hearing of similar reactions, I believe that condom use is viewed with criticism and concern by the Maasai. Forty-three percent of my participants talked about issues surrounding condom use. Condoms are introduced from outside of their culture and lower the rate of reproduction, a core value in their culture.

There did seem to be a difference in women’s perceptions of prevention depending on whether or not the husband had gone to school. If he had attended school he was more willing to talk about faithfulness or condom use. “We have advised each other, and agree not to stroll\textsuperscript{22}. I said if he gets another wife, I will also get another friend” (Are). The husband of this participant attended school up to standard eight. With men who had not attended school, the women felt they could not even bring up the subject. Following is a quote from a women who has never attended school and whose husband never attended school:

---

\textsuperscript{21} _Ehhh_, is a phonetic sound in the Maa language to indicate agreement.

\textsuperscript{22} “Stroll” refers to having sex with other people.
Uh uh\textsuperscript{23}, there is none, because this is a hard thing. I know only that I, myself can stay [abstain]. But, for my husband there is no way to tell him he can’t go somewhere. You won’t know what time it will come. Today if he sleeps outside, and then he comes, how will I know if he got it there? (Onguan)

Almost all the participants were aware of POH, and of the opportunity to be tested for HIV/AIDS at that location. One participant had actually gone for testing with her husband.

“I went first. I hide it. I was tested and saw my blood was good. I came to talk to him until we went and saw there was none. We were told if we didn’t believe it to wait 3 months and come again. We waited three months, and I told him let’s go. We went and found that there was nothing”. (Arobanne)

Reactions varied depending on age, and it was interesting to hear them. Overall, 35\% of the participants talked about HIV testing in their interview. Most saw no point to testing when there is no cure, and in most cases, they felt there was nothing they could do to change their exposure to risk.

Not everyone wants to know how they are. They don’t want to know if they are sick. (Naapishana)

You want to test people and then they hear if they have the disease. [Laugh]. For what reason when this disease has no medicine? (Onguan)

Ehhh. And others will refuse, they will say let me just stay, if I have it, I don’t want to know. If people know they will go to the river and get in, what are they doing? (Illay)

\textsuperscript{23} Uh Uh, is phonetic emphasis in the Maa language indicated disagreement
The younger girls attending school talked about their future plans to be tested before marriage. “One day I will find someone to marry, and go to a VCT with him, and see if I am positive or he is positive, or I am negative or he is negative” (Sita).

The older women felt the best way to help their daughters avoid contracting HIV/AIDS was to continue talking with them and trying to find money to give them so they can buy the things they want. “It is to talk to them, try to talk to them. Like me, I talk to my girls. I talk to them. And I try, if she asks for something, the big girls, I try to find a way, even if the young ones get mad. Least let them get mad, and the older ones get the thing she wants” (Nne). “Every Saturday I go see her. If she has a problem with clothes, if she has a problem with money, I bring it to her. I watch out for her very much” (Tisa). Mothers believe their girls are protected from having sexual relationships with men if they do not need money.

5.2 Poverty

All of my participants across age groups agreed on one fact-the need for money was problem. Forty percent of participants related money issues to HIV/AIDS. As one participant explained, “it is money that brought this problem with this disease. Let me tell you, it is money that brought it. It is money. This disease comes, and it is money that brings this problem” (Arc). (Naapishana): “You know if you really look at it, it is money that brings problems. If a person has no money, they can’t stay without eating or stay without wearing clothes”.

The need for money varied with age. Among married women, the biggest need for money was to feed and clothe their children. Men made references to women as supplying all needs for the children. While the husband is the head of the household, it seems an unspoken rule that the women take care of the children. This includes finding a way to pay for their needs. One man explained to me the difference between his two wives. His first wife had left him and moved to town, rumor had it, to live with her boyfriend. Her children were well fed, well dressed, and all attended school. His second wife stayed at home every day. Her children had rags for clothes, were always hungry, and only one of five were in school. The husband exclaimed, “That woman really has a problem with all of those kids”. The entire conversation was of interest to me because he referred to them as if they were not his responsibility. Their
poverty was his wife’s problem. Phrases like this were often repeated by men and women everywhere in the community. Women have difficulty in trying to supply all the needs of their children by themselves. Many older women had never been to school and did not have many options for earning money. The only alternative for most of them was earning money through sex.

The words women use really demonstrate how they see their economic transaction. Women described their boyfriends and their sexual relationships as “work”. “And that work with your body. She plans ahead and sells her thing” (Are). “Their work it is money that brought it the disease. Let me tell you, it is money”. (Are)

One woman described her struggles trying to make ends meet.

If you get flour, you cook *ugali*, and you can start to make porridge. You start to see the children begging for mercy because they are not eating well, but you can’t cook a lot of food because there is not enough for all the children, so you start to see them begging for mercy, so your children have a problem when the corn is in the store. Because for now you take the corn. You go to grind it. If there is no money for grinding, you roast corn for them. And clothes, you see so many problems. Because if it is the husband he starts to see this work is heavy, to buy 8 children clothes, so he starts to see this work is very big. So, I use my intelligence, if I get money from beadwork orders from [deleted for privacy] who is helping, if I get money I split it and buy clothes for one child, or two, or three, like that, like that. So, we start to see, you start, like now you think, everything, there is nothing, it is problem. Like your husband will have no happiness at your house, because you want this, if you tell him he will say there is no money. (Nne)

Here is another woman’s description of the years immediately following her husband’s death. She also struggled to feed her children. Now she says things are easier because she has a steady boyfriend. “I slept hungry. And again I go in the morning to look for food. I cook. These days it is better” (Illay).
The young women on the other hand described a completely different need for the money. While most of the literature I read showed that young women also need money to buy essential survival goods such as food and clothes, all of my young participants who were in school identified the following objects young women buy with money earned from sex:

“They buy lotion and nail polish. These things.” (Mbili).

“Like lotion to rub, she buys. Because her parents can’t afford. So, she uses this way to find it” (Sita).

The other interesting difference between the age groups is that while the women referred to these transactional relationships as “work”, the girls referred to it as being “helped” or “tricked”.

“Girls are tricked with money” (Moja).

“There are others that trick you with money, it is not good” (Tano).

“Clothes, shoes, or lotion to use. So they want money, and they go to get a person with money that tricks them. They give them money, and maybe that person is sick, and he will transmit it to them. And then when you are infected, you don’t know you have it, and you continue to go with other boys that come. It is how the disease goes around and gets girls” (Naapishana).

“Girls are the only ones tricked by old men, and they go to have sex with them. You see many girls get AIDS because they get it from old people. But, boys can’t get it” (Msichana).

Women and young girls alike described the courting part of their transactional relationships the same way. The man approaches the female and offer money first, maybe 100 Kenyan shillings. The man may offer and give money several times before he insists on sex. He may come and go in her life. Maybe they only meet once a month, but he will give her a little money to insure they can have sex the next time. This is why many women have more than one boyfriend.
All of your friends cannot come together at once. One can get lost for 2
months. You meet in town, and he can give you 1,000/= after 2 months or 3
months, it depends on the timing of a person. (Moja)

“It is not one day. If he comes one day he gives you money, 500/=". (Tomon)

“Money for girls, they may get 100/=, if it reaches high maybe 300/>."
(Digatom)

Poverty and the need for money were themes in all of my interviews. The
reason for needing money varied depending on the age of the women. Women feel so
desperate that they are willing to put their lives at risk to obtain the money.

5.3 Sexuality

Most Maasai women are very sexually active. They view sex as a natural part
of life and a bodily need. During my years living in Narok, women would ask me all
the time what I did about sex. I told them I just abstained. This response was met
with laughter and annoyance because they thought I was lying. Women often told me
you can’t simply go without sex. One participant pointed to the difference between
cultures in this way. “That’s your tribe, but for Maasai, women can have even 10
friends” (Moja).

One participant lived at the Manyatta for seven months the previous year.
When I asked her what happened sexually, she laughed and told me that some women
were there only to have sex with the young Murrans24. “Ehhh, they really sleep with
people” (Illay). She told a story of two women getting into a fist fight over one
Murran lover who had been sleeping with both women.

As with most societies, sexuality is acquired through social learning. Views
and perceptions are passed down from mother to daughter. Young girls watch their
mothers and learn the expected behavior. One participant blamed this learning for the
spread of HIV/AIDS. She explained that many women slept with a large number of
men, and then their daughters imitated that behavior. “But, girls see the way their
mothers behave and follow it. If Mama has good manners, then the girls have good

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24 Murran is the name of the age group for young Maasai men. It is the warrior age.
manners\textsuperscript{25}, they follow their Mama” (Tisa).

Many of the young girls I interviewed mentioned “heat” in the body. I asked one participant why young women had sex with so many men. “[Laugh], it is just the heat of the body” (Tomon). This same question and response came up in the focus group discussion. One of the young women mentioned that an HIV/AIDS educator in an awareness lecture recommended taking a cold bath if they needed sex. She tried to explain this notion to the other girls.

Mbili: \textit{Ehhh}, if a person feels the heat, go bath in cold water.
Mwanafunzi: It will come out?
Mbili: I don’t know.
Mscichana: You go to pray to God.

The most interesting aspect of this short dialogue was the sincere desire of Mwanafunzi. She asked the question in earnest, honestly trying to find another solution to get the heat out of her.

As with so many other aspects in life, AIDS is also changing sexuality and other behaviors. One participant explained this change, “In the past it was good, because there were no diseases like now. But, these days it is bad, because this disease has really increased. These days they try to protect. They are afraid to be with others, they go to church, they left that issue” (Tatu). Changes in sexuality are more prevalent in the younger generation. People speak about how things are not the same anymore, and how Maasai can’t behave in the same way. One example is the meaning of pregnancy. In the past a young mother had no problem getting married, because her child born out of wedlock was proof that she was fertile. Now a young mother may find it somewhat difficult to get married, because it is physical proof that she has had sex with other men.

\textsuperscript{25} “Good manners” is refers to a faithful and monogamous wife.
5.4 Education

One of the most surprising aspects of my results was the different ways in which the education system is increasing the spread of HIV/AIDS. Education for Maasai young women is still a new phenomenon. Many Maasai young women who are currently in secondary school are the first in their families to have achieved to this level of education. Traditionally young women were married around age 13 to 15. Now, young women are waiting until they finish school to get married. Their education conflicts with traditional cultural norms, leaving the young women in the middle struggling for a way to achieve their own goals while still respecting their social roles.

One of these struggles is finding resources for school fees. Since education is such a new thing, especially for girls, Maasai men struggle to justify paying for their daughters to go to school. One participant explained the difference between paying for boys and paying for girls to attend school. “Fathers in Maasailand can’t help girls.... They say girls don’t have any profit. They don’t have a profit for the boma. ... She will be given away, and then she will help her husband” (Naapishana).

The traditional norm of a girl’s early marriage marking the end of her father’s responsibility is now at odds with education. Young women feel trapped in this change. Their mothers are trying to find resources to provide for them while their fathers cannot or do not. Another participant explains why she had to drop out of school. “It was because I was being paid for school, and Mama has no way to pay for me” (Are). Her Mama was expected to look for the money, not her father.

Another young participant complained because she finished secondary school and wanted to attend college. She has already been accepted, but her father refused to pay for any more tuition. I asked her if it was because he didn’t have the money, and she did not hesitate in saying no. “No, you find others, ones that I studied with in school, to this homestead here is richer. You know that homestead of [name deleted for confidentiality] the elder of that homestead died a long time ago. The girl there was studied because of her Mama. Right now she is in another college in Nakuru, second year” (Tano). Again she refers the girl’s Mother finding the money to pay for school, not her father. Often the mothers or the girls themselves find boyfriends to
help pay school fees. This stress related to the cost of education is happening at the time of the HIV/AIDS epidemic.

Furthermore, the education system places higher demands on young women and parents for material goods. There are a few local primary schools close to the sample area, so students attend rural day schools for their primary education. Secondary schools are more limited in number, and most of these are located in Narok Town, which means the secondary students are in urban boarding schools. The young women in secondary school feel such a high need to assimilate that they are forced to find resources to buy Western goods. This finding was mentioned in the section on poverty, but it is important to reiterate that education has impacted their desires. Through the focus group discussion on monetary needs it became obvious that while young women in rural schools wanted money for clothes or food, young women in urban schools wanted money for lotion or nail polish. One participant explained this situation poignantly.

Or like now, I have seen this twice, you see others that have a canteen\textsuperscript{26}, and you were given enough money from your Mama, and you find this girl, she is your friend, and you see she has no money, and she doesn’t want to tell you. Maybe she has begged many days, and she sees that she is a problem. But you haven’t refused her; you give it to her. She will wait and see. She will go to sell herself. (Msichana)

5.5 Pregnancy

Education has had an impact on pregnancy. Traditionally a girl is only allowed to become pregnant after circumcision. Pregnancy was an accepted next logical step in life. Today the girls are in school, and pregnancy is an enormous challenge. A girl who gets pregnant while in school will most likely have to drop out of school and get married.

If a girl gets pregnant when in school it is not good. Her parents will get mad.

\textsuperscript{26}A canteen a places that sells small snacks such as soda and chips.
But, like me, if I get pregnant while at home they won’t get mad, because it will be hers, because I persevered through school, I also got, there is no fault. The point is that there is a problem when in school (Tano).

One universal theme in my interviews was the shame if a girl got pregnant before circumcision. No matter what the participant’s age or education, this action is seen as one of the worse things a girl can do to her family. “If you get pregnant before circumcision it is horrible. You will run away. You can’t even see your parents. You will run away completely” (Tatu).

Some women said the harshness of the reactions depended on the family or the father. Traditionally, the girl was kicked out, married off, and could not return until her child was walking. Even then the relationship was never the same. “Here, it is very, very hard. You will get a husband right then because maybe there is another homestead that wants her. She will be given there and then circumcised. Her parents won’t want her again in their homestead” (Onguan). If the father is more lenient, then he may agree to the girl staying home. Either way, the constant social reality is that the girl will be circumcised before she gives birth, no matter what.

A typical circumcision ceremony involves gathering food to prepare, slaughtering animals, and making ceremonial beer. From 20 to 100 people attend on the day of the celebration. Forced circumcision due to early pregnancy is different. “There is no big ceremony, like the one you do if you weren’t pregnant. You just call the person who comes to perform the circumcision. There is no beer. There is no food. You are just circumcised like that” (Moja).

The affects of a young girl having a child are also changing. It use to be that if a girl had children before she was married, it was not a problem. It was a sign of fertility. Today young men don’t want to marry girls that already have children because it is sign that she has slept with other men. “Or she can’t get a husband, because young boys don’t want a girl who is pregnant. These days they don’t want you. If you are big and pregnant you stay with your Mama” (Onguan).

Family planning is offered at the governmental district hospital. Maasai women and girls increasingly are turning to family planning. Most use either the birth
control pill or depo prevara shots. They also use some traditional methods of family planning with herbal treatments or post-natal abstinence. One participant told me that at sometimes men practice the withdrawal method with their girlfriends or wives. Since the consequences of pregnancy before circumcision are so severe, I asked participants what prevention methods they use. They all said ‘abstinence’.

5.6 Learned Helplessness

Most participants had come to a point of frustration with HIV/AIDS. They talked about it everyday. "If you can’t get better, that is the problem Naserian" (Onguan). Women don’t feel they have any options for preventing this disease, and since they feel it is a death sentence, they don’t want to discuss it or consider their risks. “I will be afraid when I can’t do anything? I will be afraid and really what will I do then. You know this sickness has become widespread in this area” (Nabo). They are fatalistic. Many participants talked about how there is nothing that can be done, that this is the end. These quotes capture the sentiment. “This disease is very very hard. God said, ‘Let me bring a disease to finish all people,” and then he will bring others” (Illay). “If you know a reason, if you know you will die this day, you are just waiting for death. You will go far, and die far. You know for Maasai women it is like that. You are afraid. There is nothing to be afraid, just that” (Onguan).

Many women now feel the only choice left is to pray to God. Throughout Kenya, church attendance and conversion to Christianity has grown as the epidemic has grown. Women frequently explained to me that this is what they were doing to prevent the disease. “I will just pray to God. It is just God” (Illay). “Let me tell you, the state of the world. I pray to God. I said, ‘Let me go to church, and stay in church, and pray to God, because it is only God that can help me’” (Are).

The most astounding finding of this entire research project was to discover how young women currently perceive AIDS. “These days they say AIDS is a cold. They don’t care” (Mbili). This phrase was so shocking to me. I could not understand why AIDS would be considered a cold. After the first participant explained this term, I started asking all the young women how they viewed AIDS. I got similar answers.

27 Naserian is my Maasai name, many people refer to me only by this name.
“They say it is a cold, and death is just death only. Death is a must. Death is a must” (Msichana).

All the young women with these perceptions were in urban secondary schools. Every one of these schools has HIV/AIDS awareness classes. These girls are well educated on transmission, prevention, and progression of the disease. Could they be overeducated? They are well aware that the disease is widespread across the world. They are educated to the point where it seems they have given up trying to fight it. They are too overwhelmed with diseases to care. “Or at times you have other diseases, like Hepatitis B. Other times it kills, and there is no medicine, and Ebola. So they say if these others can reach us, and sex you are doing, you see you will just die. This is how they see it” (Msichana).

The feeling of learned helplessness or fatalism has resulted from perceptions that death is everywhere and impossible to prevent. “They say death is death. Not all are afraid. Many say, I will just die. Even if I don’t have it, I will die. Let me die with her” (Sita). So if you are going to die anyway, why not enjoy yourself on the way? “Ehhh, that is what they say, death is death. The same one. Heat is heat. The same thing. The one of gossiping. They will go to the heat, you will burn the last day, and if you do other sins you will burn. So to have sex you will burn. So you might as well do it all, like every day, even to kill other people if they can” (Msichana).
Chapter 6

DISCUSSION

There are many underlying causes of Maasai women’s risk for HIV/AIDS. These causes include cultural practices and social learning about sexuality. The results of this thesis, however, show the stronger underlying causes of HIV/AIDS transmission to be women’s poverty and current interventions.

6.1 Poverty

Poverty and specifically women’s poverty must necessarily be addressed before any HIV/AIDS campaign can be successful. Until a person’s basic needs for food, shelter, and safety are met (cf. Maslow 1970) it is unrealistic to expect a change in present behavior to prevent future illness. This is especially true where the required behavior change reduces the ability to meet basic needs; for example abstinence from the sexual reciprocity that provides resources to feed children. “Further, perceptions of risk can be affected by the concerns of the present and the probable prospects for the future. When the future is bleak and immediate survival in question, the ability to take a long-term perspective on risk might seem like a luxury” (Fenton 2004: 1186).

It is important to understand that poverty in this study is adversely affecting women. The culturally defined socioeconomic data collected at the level of the household showed a number of families where the men were classified as high income, while the women were classified as low income. Maasai women have little control over economic resources and are expected to care for their children. This entails finding the means to care for them (i.e. clothing, food, daily needs). Men make all decisions over how money will be spent, in many instances household resources are spent on the issues the men feel is most needy, which may not be the welfare of the children. Since women do not have control over the household resources, they turn to people outside of their households for assistance. In many cases this assistance comes from boyfriends, they will give resources to the woman in exchange for sexual interactions. This complex linkage between gender and poverty exposes women to a high risk of contracting HIV. Since women do not have control over household resources; simply increasing the resources in the household would not address the link
between poverty and HIV/AIDS because the particular situation of women would not be addressed. Interventions need to be designed with the specific target of increasing a woman's economic viability, which in turn would decrease her risk to HIV/AIDS.

The difficulty in addressing poverty is that it represents such an overwhelming multifaceted problem that no one is sure how we can or how we should address it. Simply ignoring the problem is not the solution. As difficult as it may be to significantly impact poverty, it is essential that interventions continue. The fight against poverty and the fight against AIDS must go hand in hand. “First, since poverty plays a role in creating an environment in which individuals are particularly susceptible and vulnerable to HIV/AIDS, poverty reduction will undoubtedly be at the core of a sustainable solution to HIV/AIDS” (Fenton 2004: 1186). Until we can find a way to address poverty and its affects on all aspects of life, especially sexuality, we will be unsuccessful at reducing AIDS transmission rates.

One way of addressing women's poverty could be through training. If some AIDS funding were allocated to technical skills training for women then poverty could be addressed while reducing the risk of AIDS. If women had another reliable means to support their children, then this would reduce their need for multiple sex partners. As one participant explained to me, if a mother has more money then not only will the mother's risk be reduced but also the girl's risk, because the mother will look after the girl. “She will know her daughter wants this thing. And her daughter will be able to tell her what she wants, because she knows her Mama has money. But if the girl knows her mother doesn't have work, she will go outside” (Naapishana). Important consideration must be given to skills training. In contrast to current interventions, training must be locally and culturally appropriate as well as economically viable.

It is now essential that AIDS funding policies be broadened to include measures of addressing poverty reduction. Simply targeting AIDS prevention is not enough. While poverty reduction is an extremely large and difficult issue to address, it can be done on a community level. The redirecting of AIDS funding from simple awareness campaigns to poverty intervention could be one turning point in the fight against AIDS.
6.2 Current Interventions

Current AIDS interventions have not been effective because they are not taking into account the specific cultural factors that are contributing to the spread of the disease. Western nations have launched HIV/AIDS interventions that are dependent upon individual behavior change to prevent HIV infection. While such a campaign may work well in societies that are individualistic, they fail drastically when dropped into a community-based society. Most African nations have a strong community-based culture. Children are taught social norms and gender roles from childhood, and they are expected to fulfill these norms and roles through marriage and sexuality. Some of these behaviors may place youth at risk. Until there is a change in social norms and roles, it is very difficult to expect change on an individual level.

Most people in Kenya and in Narok are highly knowledgeable about HIV/AIDS. Awareness campaigns have been effective in this respect (Central Bureau of Statistics (CBS) [Kenya]: xxii). However methods of prevention that are recommended are not only ineffective but even detrimental. Because these preventative measures are beyond Maasai women’s volitional control, the women have now adopted a fatalistic attitude towards HIV/AIDS. They feel they are helpless to stop the infection and do not care or try to avoid it.

When the phrase “AIDS is a cold” was first communicated to me in an interview I was completely shocked. I had no context even to understand what that meant. What do phrases such as “AIDS is a cold”, “Death is Death”, “Your grave is your grave” really mean? As the young women repeated these phrases, the general theme became clear to me.

“Another relevant feature of adolescent belief systems is the heightened fatalism sometimes expressed at this age, which is encapsulated by the idea that one has little control over what happens so there is no point in taking precautions” (Bandura, 1997; Moore & Rosenthal, 1991). On the coding these interviews it became apparent to me that to these young women, AIDS is infecting everyone, and there is no way to avoid it. So why try?

The young women with this world view had one thing in common. They were all in secondary schools with HIV/AIDS awareness programs. In contrast to village
participants they were well educated about HIV/AIDS. They knew how the virus is transmitted and how it is prevented. In many cases they even knew the biological process of how AIDS affects the immune system and how a person dies from related diseases. They were aware of POH and other testing facilities, and some had even visited the facilities. But these were the same participants who showed the highest perception of fatalism.

When interventions are not culturally appropriate they may actually reduce individual self-efficacy because they will not possess the skills to perform the preventative behavior in their own social environment (cf. Lerman and Glanz 1997: 119). “The problem with these campaigns is that they fail to take into the account the reality of women’s lives and the special risk factors that make them vulnerable” (Ackermann 2002: 166). HIV/AIDS programs in the schools are not only ineffective because of their disregard for the reality of Maasai young women’s lives, but they are also detrimental to the young women’s health because they lead to fatalism.

Current prevention strategies taught to young Maasai women are contradictory to their sociocultural learning. HIV programs in schools teach the A,B,C options for prevention. Young Maasai women receiving this information are in a dilemma. In secondary school, young women have already become sexually active. Previously most young women age 16 to 18 would have already been married and have given birth to one or two children. Socially sexual activity is still reinforced by sociocultural learning. As one participant explained, Maasai girls are encouraged to start having sex in order to learn the lessons they need before marriage. “You know Maasai, their behavior, a long time ago they can give their daughters away when they are small. So if they become big, they are taught the work [sex] and when they are small they know the work [sex] of a man” (Arobanne). In this context it is understandable why the “A” for abstinence in the prevention model is not appropriate. “Young women’s vulnerability can be attributed, in part, to family and societal concepts of masculinity and femininity that are communicated during childhood and adolescence” (Weiss: 241). The “A” contradicts everything the young woman has learned socially.

The “B” for being faithful to one partner is also socially inappropriate for the Maasai community. The Maasai are a polygamous society. While this practice is
changing, it is still a social norm. In the past a man would have anywhere from three to five wives. Today a man may have from one to three wives. All the young women who spoke so fatalistically of AIDS came from polygamous families. In school they are taught that ‘being faithful to one partner’ is one of three options for preventing HIV/AIDS. How can a child from a polygamous family comprehend this? The “B” contradicts everything they have learned socially since childhood. Furthermore, they will likely find the recommended behavior impossible to adopt in that context of their culture where frequent sex is regarded as necessary. If a woman cannot find a husband who agrees to only one partner, she remains out options.

The “C” for condom use is also inappropriate for the target population of young women. In chapter two I discussed the resistance to condom use in Maasai society. Now I would like to look further at this struggle from a young Maasai girl’s perspective. Women and girls do not have the power to request a man use a condom. The young women understand their low status in society. It is easy to observe their quiet submissive tendencies when other people are around. This status is reinforced for most of her life. Then interventions tell her she must take control and insist that a male use a condom. Is this reasonable when she has never been able to insist that a male do anything?

These three options are the only ones given to these young Maasai women to prevent HIV/AIDS transmission, and all are socioculturally impractical. It is easy to understand why the young women are feeling so fatalistic. Through their school HIV/AIDS programs they have now learned enough to realize that this disease is serious and widely spread. What they have not learned is how they can prevent the disease. I can speculate that some of the young women may have tried A,B,C prevention options, but they are difficult sustain because they are so culturally unrealistic.

The original research question considered in this project was what cultural factors was putting young Maasai women at risk. The results have shown how the risk

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28 A Christian Maasai has only one wife. In asking about Christian men I found the answer will be “he is saved”, which means only one wife. Even though this social norm is in the process of change, it is still important to recognize how polygamy plays a role in both the transmission of HIV/AIDS and prevention options.
for HIV enters a Maasai girl’s life. Though my research was not intended to address young Maasai men, I would like to briefly discuss possible reasons why young men of the same age category are not contracting HIV at the same rate as young women. First, young men do not have access to as much money as the older men. When young women are looking for economic benefit from sexual relations they turn toward older men. Second, young Maasai women are traditionally married to men who are somewhat older. The older men are considered to have the wisdom and experience to care for the young women. It is more natural to have older men as sexual partners than men of the same age. Third, as explained to me through a participant, it is taboo for young men to sleep with uncircumcised young women. They will be interrogated during their own circumcision over this issue. If one has slept with an uncircumcised girl, he will have to pay an extra cow as well as suffer shame to his family. These social facts and taboos explain why Maasai young men have a lower risk for HIV.

It is essential that HIV/AIDS campaigns be culturally appropriate. Every community’s culture has specific social values that must be fully understood to construct any intervention design. “Each community needs to be studied in terms of the local situation and the preventive measures advised and facilitated for residents must take account of the differences between communities” (Susser 2000: 1042). If recommended prevention behavior contradicts with social values, a person in many cases does not have the power to change their behavior and better their health.

Where does that leave HIV/AIDS prevention in Narok? The interventions now being used have been developed in Westernized nations with Westernized perspectives, far away from Narok reality. It is not only time to “go back to the drawing board”, it is time to taking the drawing board to Narok. Let Maasai develop interventions that are appropriate for them.
Chapter 7

RECOMMENDATIONS AND CONCLUSION

This study was conducted with an anthropological focus. The goal of the research was to understand local beliefs, attitudes, and perceptions about HIV/AIDS. As an anthropologist I was able to use the skills of participant observation, in-depth interviews, demographic data, nutritional anthropometry and analysis to bring qualitative contextual descriptions into an analytical and academic perspective. This study is intended to be the foundation for establishing a culturally appropriate intervention.

Behavioral change must begin in the social network of the culture. We must give people the information and understanding of how a specific practice may cause harm. The community must determine and teach the most effective way to implement an intervention program. Change must come slowly if it is to be respected and followed. Maasai themselves are in the best position to implement such a program.

A specific goal of intervention would be increased awareness among elders about specific risk factors for young women. In Maasai communities, people bring problems to local elders. The elders meet, discuss the problem, and develop a solution. This form of local governing is so effective that even non-Maasai governmental officials in Narok tell those involved in Maasai disputes to settle them with their “Maasai words”. Since most community problems are handled in this way, why should HIV/AIDS be any different?

HIV/AIDS is affecting all aspects of Maasai life. It is threatening the survival of the population. This is certainly a problem the elders would consider important enough to address. To my knowledge they have never been given that opportunity. Outsiders have come into the community and set up their prevention programs without ever consulting local elders. The only interactions I have seen involving the elders is where outsiders have given introductions and tell the elders what to do. Never once have I seen the elders approached to solicit their opinion. I propose doing so. I recommend commencing a meeting of Maasai elders to explain the current HIV/AIDS
situation, the modes of transmission, and behavioral risk factors. Then allow them to set up a culturally appropriate form of intervention.

I must emphasized that women need to be involved in the intervention as well, since it is the women who look after the well-being of their children. As mentioned earlier, this is one of their major roles in life. Women are currently searching for ways to protect their young daughters from contracting HIV, either by counseling them or by giving them money to buy the things they want. Furthermore, some elders in the community are the same sugar daddies who put the young women at risk. Therefore women are needed at the design table.

This research was conducted solely with women. The recommendation of having a meeting with elder men comes from my knowledge through past experience of living in this community. I am aware of the local governing systems, and therefore know that a meeting of elders is one way an intervention could be approached. However, since the this study is based on interviews with women participants the results can only speak to address women’s issues. In the traditional sense ‘elders’ would refer to Maasai men, however, in this recommendation ‘elders’ includes women as the primary catalyst for action. While culturally the men will have to give recommendations and permission for an intervention to take place, it should be the women with the control over implementing the intervention.

The anthropologist has a significant role to play in community based intervention. The anthropologist should continue to act as the cultural broker, explaining HIV/AIDS risk and translating medical language to the community. The anthropologist can also act as a catalyst, helping the community elders design and make their interventions a reality.

7.1 Outline of community intervention plan

The total implementation time for such an intervention would take almost one year, each phase requiring about two months.

Phase 1: Ethnographic Assessment

- Use ethnographic interviews, focus groups, participant observations to understand the beliefs, knowledge, attitudes, perceptions, and perceived risk/susceptibility
concerning HIV/AIDS. Special attention should be paid to perceived skills-mastery, self-efficacy, behavioral control, and volitional control.

- The research objective is an in-depth understanding of the factors contributing to the spread of the disease in a specific community, going beyond a literature review of other communities.

Phase 2: Initial Meeting with Elders and Opinion Leaders in the Local Community
- Commence a meeting with the elders and leaders in the community to explain the problem and the results of the research.
- Explain what behaviors place the young women at risk for contracting HIV/AIDS.
- Enlist suggested methods of change that are considered realistic and accepted by the community.
- Encourage effective communication of sexual topics.
- Discuss and lay out the design along with a timeline for community intervention.
- Ask the elders to initiate a behavior change campaign through a grassroots coalition.

Phase 3: Secondary Meeting with Elders Coalition
- Ascertain any skill or resources elders feel they need in order to be successful.
- Present other facilitating conditions that affect the long-term sustainability of intervention (e.g., poverty, early marriage, education costs, and female circumcision.
- Enlist suggestions from the elders for sustainable ways to address these conditions.

Phase 4: Evaluation of intervention
- Use ethnographic interviews, focus groups, and participant observations to understand the beliefs, knowledge, attitudes, perceptions, and perceived risk/susceptibility concerning HIV/AIDS.
- Compare the outcomes to objectives from phase one.

This is simply a draft of how such meetings might evolve, not a comprehensive guideline, which is impossible because individual community member’s roles, gender roles, and politics will dictate the evolution of the program. The essential component of such an intervention is that the elders of the community are in control over what they want to do with the information they receive. There is no guarantee the
community will decide to do anything with knowledge of the risks. There is also no guarantee that a community intervention design will be successful; however at this point anything is better than current detrimental awareness programs.

7.2 Future Implications

The most important aspect of this research is that it was approached and carried out in an applied fashion. My participants did not tell me their stories, explain their perspectives, and share in their lives just for me to take their words and publish them. They participated in the research because they were given hope that the results may help them in their fight against AIDS.

Kenya has become a very "donor dependent" country. Even in Narok one of the most well-known English words is "proposal". Local residents understand that many people and organizations come to the community with the hope of implementing a development project. The project often fails and residents notice that the people who wrote the proposal receive a lot of money despite failure. One of the households that refused to participate in this study accused me of the same thing. "She will just go make money off of it". I am well aware that there are many other jobs I could easily do to make money rather than lugging anthropometric equipment through 20 km of hot dusty African bush, but my participants are not. In their eyes, I came and recorded their stories and words. Now I am gone. If I never return with the results of my work, they will believe that I took their words and made money from them. It does not matter whether this is true or not. This is where the applied part of applied anthropology is so important.

Collecting the ethnographic information from this research was an essential start in the process of developing an intervention. I had no idea before of the negative effects resulting from the A,B,C HIV/AIDS awareness program. I also had not read any research documenting these negative effects. I discussed these effects through in-depth qualitative interviews. If I had used a survey, the information most likely would have been overlooked. This study is an important example of how applied anthropological research can be influential in public health development. Since most HIV/AIDS campaigns around the world use the A,B,C approach, it is essential for health practitioners to realize how such culturally inappropriate interventions actually
increase transmission of the disease. This A, B, C approach is maybe equally inappropriate elsewhere, especially in other African countries with cultures similar to the Maasai. Communities in other places need to evaluate the impact of such interventions immediately. Where interventions are decidedly detrimental, the awareness campaigns should stop until a new design can be implemented. It is important to keep in mind that a similar evaluation must contain qualitative methods, since a quantitative survey method might never uncover the fatalistic perspective.

I plan to turn my research over to the Narok Maasai community. My recommendation, as outlined above, is to use participatory action research for the next stage of intervention. I feel the best intervention for an indigenous community such as the Maasai would be one designed and run by themselves (cf. Ervin 2000: 199). It is the elders in my sample area who have all the local knowledge and power to assist any type of behavior change that would lower women's risk for contracting HIV/AIDS.

I will deliver this research to POH, the most active community based organization working on HIV/AIDS programs. A part of their program is HIV awareness. They are likely to be receptive to my results and negative effects of current HIV education. I will explain my recommendations for participatory action research and hope that POH can help to implement such an approach.

Social norms and roles can to change. "Sexuality, as a culturally shaped aspect of life, has always undergone adjustments in response to internal or regional dynamics in Africa-as have religion, agriculture, and political organizations" (Setel 1999: 28). The changes and adjustments to social facts or norms are best implemented in a sustainable fashion where the change comes as a social current from within the community. This is why a participatory action research approach is appropriate. Simply telling young women to change their sexual behavior is asking them to do the impossible within their social context. If elders encourage alternative behavior there is a very real possibility of change.

This kind of intervention will achieve two main objectives that are important for the Maasai community. First, any behavior change supported by the elders will inevitably lower the risk for HIV/AIDS. To what degree the risk will be lowered is uncertain, but there would at least be minimal improvement. Second, an intervention
that is led and run by the elders will insure that the cultural identity of the community remains in tact. Culture is a fluid, evolving phenomenon always subject to change. Dangerous change results from new initiatives that come solely from outside the culture. If change comes from inside the culture then cultural identity can be protected. I believe these two goals should go hand-in-hand.
Appendix A  Demographic Survey / Nutritional Measurements

Demographic Data

<table>
<thead>
<tr>
<th>Name</th>
<th># of wives</th>
<th>D-No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age/Age group</td>
<td>Amount of milk produces/sold</td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
<td># Beads women have</td>
<td></td>
</tr>
<tr>
<td>Age of marriage and marital group (ie number of wives)</td>
<td>Pit Latrine present</td>
<td></td>
</tr>
<tr>
<td># of people living here</td>
<td>Number of children born/died last year</td>
<td></td>
</tr>
<tr>
<td># of bomas (huts)</td>
<td>Total number of deaths last year</td>
<td></td>
</tr>
<tr>
<td># of cows</td>
<td>What did they die of?</td>
<td></td>
</tr>
<tr>
<td># of goats</td>
<td>Main source of income for the household</td>
<td></td>
</tr>
<tr>
<td># of sheep</td>
<td>Source of water for the household</td>
<td></td>
</tr>
<tr>
<td># of children/</td>
<td>Where does the household seek medical treatment</td>
<td></td>
</tr>
</tbody>
</table>

Other Information:

Nutritional Anthropometry

<table>
<thead>
<tr>
<th>Name</th>
<th>Height</th>
<th>NA-No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Weight</td>
<td></td>
</tr>
<tr>
<td>Tribe</td>
<td>Mid Arm Circumference</td>
<td></td>
</tr>
<tr>
<td>Village</td>
<td></td>
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</tbody>
</table>
Appendix B IRB Oral Consent Form

INFORMED CONSENT FORM

Project Title: HIV Vulnerability of Maasai Female Youth
Principal Investigator: Dr. Sunil Khanna
Research Staff: Naserian- Kristin Peterson

You are being asked to participate in a school project.

Before you agree, I must tell you:

1. This project is to try to understand why Maasai girls get HIV/AIDS, in order to help slow this disease transmission among the Maasai. Your interview will help the success of the project.
2. You may have concern or feel uncomfortable with some questions, if so simply tell me and I will stop the interview.
3. All words in this project will stay here, I can not tell other people you are the owner of these words.
4. Participation in this project will take one afternoon.
5. I will do this project with about 15-30 women.
6. You will be told about any results for this project by beginning of September, 2004.

You may contact Joseph Kipila at Pillar of Hope VCT in Narok Town any time you have questions about the project. This center has free counseling.

Joseph Kipila
P.O. Box 642
Narok, Kenya
722-882134

Your participation in this project is voluntary; there is no problem if you decide not to participate or if you decide to stop participating during any part of the project.

OSU IRB Approval Date: 04-06-04
Approval Expiration Date: 04-05-06
References


